

BEFORE THE TENNESSEE  
HEALTH SERVICES AND DEVELOPMENT AGENCY  
NASHVILLE, TENNESSEE

IN THE MATTER OF: )  
)  
SBH-KINGSPORT, LLC, )  
)  
Applicant, )  
)  
vs. ) Docket No.  
) 25.00-126908J  
)  
TENNESSEE HEALTH SERVICES )  
AND DEVELOPMENT AGENCY, )  
)  
Respondent, )  
)  
and )  
)  
MOUNTAIN STATES HEALTH )  
ALLIANCE, )  
)  
Intervenor. )  
\_\_\_\_\_ ) VOLUME 1 OF 5

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TRANSCRIPT OF PROCEEDINGS

Taken before Administrative Law Judge Leonard Pogue

Commencing at 9:00 a.m.

July 27, 2015

**ORIGINAL**

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P R O C E E D I N G S

THE COURT: Today is July 27, 2015.  
This is the hearing for the Tennessee Health Services and Development Agency to consider the matter of SBH-Kingsport, LLC, the petitioner in the matter. The intervenor is Mountain States Health Alliance. The docket number is 25.00-126908J. I'm Leonard Pogue, administrative law judge who will preside over the matter.

Counsel, if you-all would identify yourselves for the record, please.

MR. WEST: Your Honor, I'm Bill West here on behalf of the applicant, SBH-Kingsport, LLC.

MR. JACKSON: Good morning, Your Honor. I'm Brian Jackson and, along with Travis Swearingen, I'm here on behalf of the intervenor, Mountain States Health Alliance.

I would also like to introduce the Court to my client, Ms. Kasey McDevitt, who's the corporate director for strategic planning for Mountain States Health Alliance.

MR. CHRISTOFFERSEN: And, Your Honor, I'm Jim Christoffersen, counsel for the Agency.

THE COURT: Thank you-all.

At this time, I'm going to identify the

1 technical record. And, counsel, I mentioned in our  
2 pre-hearing conference on Friday -- you may want to  
3 follow with me -- there were some orders and motions  
4 and responses along the way that counsel indicated  
5 were filed at the Agency instead of at the APD. I  
6 think eventually that, counsel, you-all straightened  
7 that out and last week had those documents filed at  
8 APD, but I'm going to try to go in chronological order  
9 of when these pleadings and motions and responses  
10 occurred.

11 The petition for a contested case hearing  
12 was filed in Administrative Procedures Division on  
13 July 17, 2014, and there's a stamp file date.

14 And, Mr. Christoffersen, just for the  
15 record, it says July 10th, 2014. That would be with  
16 the Agency; is that correct?

17 MR. CHRISTOFFERSEN: That's correct.

18 THE COURT: Okay.

19 MR. CHRISTOFFERSEN: If it's just a  
20 simple line date with no logo or anything, that would  
21 be our date.

22 THE COURT: And that's what it has.  
23 There's no reference to the Agency. There's just a  
24 date and time.

25 MR. CHRISTOFFERSEN: Especially if

1 somebody carelessly put it over words and you have to  
2 struggle to make it out.

3 THE COURT: Notice of hearing was filed  
4 on July 17, 2014. Petition to intervene was filed  
5 with APD on July 20 of 2015, however there is a date  
6 with the Agency, and my copy, I cannot read the date.  
7 So, counsel, if you-all can help me on that. And I  
8 had a petition to intervene in the file also, which I  
9 presume was emailed to me early on in the proceeding.

10 MR. SWEARINGEN: I believe July 10th,  
11 2014, was the date that it was originally filed, Your  
12 Honor.

13 THE COURT: All right. Thank you.

14 MR. WEST: If you're talking about the  
15 petition for intervention, Your Honor, I looked it  
16 up when all this discussion occurred the other day,  
17 and I think Mr. Jackson and Mr. Swearingen served  
18 it on us by email on August 1. I just thought for  
19 clarification purposes -- I think that's -- because I  
20 think that's the date Mr. Jackson also sent you an  
21 email. He copied me on it.

22 THE COURT: Well -- and that's fine. But  
23 there is a stamp "Filed with the Agency." And you-all  
24 are welcome to look at it if you want, on my copy. I  
25 just can't read it. So I'm assuming someone has a

1 more legible copy.

2 MR. JACKSON: Ours is not more legible.

3 THE COURT: Oh, it isn't?

4 MR. JACKSON: It's invisible, in fact.

5 THE COURT: Would you have that,  
6 Mr. Christoffersen?

7 MR. CHRISTOFFERSEN: Not with me this  
8 morning, but we would have it at the office. Most  
9 likely, it would be difficult to decipher. I  
10 apologize.

11 THE COURT: A pre-hearing order was  
12 entered by me on August 4th, 2014. Brief scheduling  
13 order was filed on August 22nd, 2014. Motion to amend  
14 scheduling order was filed February 25th, 2015.

15 MR. SWEARINGEN: Your Honor, just  
16 for clarification, an agreed protective order was  
17 originally filed with the Agency on November 20th,  
18 2014, and then was re-filed with the Agency -- the  
19 Secretary of State's office -- excuse me -- on  
20 July 20th, and then you signed it on the 22nd of 2015.

21 I mention that just because the parties  
22 have since -- it was an agreed protective order, and  
23 since November 20th, the parties have been operating  
24 under that order.

25 THE COURT: Okay. Well, I had the agreed

1 protective order filed on July 20th, 2015. The copy I  
2 have does not have the date you just referenced it was  
3 filed with the Agency.

4 Motion to amend scheduling order was  
5 filed on February 25th, 2015. Mountain States Health  
6 Alliance's motion for continuance and to amend the  
7 scheduling order was filed at APD on July 20th, 2015,  
8 but there's a stamp "Filed with the Agency" on  
9 March 2nd, 2015, and I also had an email copy from  
10 the parties in the file.

11 Mountain States' response to SBH's  
12 motion to amend scheduling order was filed in APD on  
13 July 20th, 2015. There's a March 2nd, 2015, filing  
14 date with the Agency, and on that matter also had a  
15 copy in the file which presumably was emailed.

16 Petitioner's memorandum in opposition  
17 to Mountain States Health Alliance's motion for a  
18 continuance and to amend scheduling order was filed  
19 March 5th, 2015. Health Services and Development  
20 Agency's response to Mountain States' motion for  
21 continuance was filed on March 9th, 2015.

22 The Health Services and Development  
23 Agency's response to -- strike that. That's actually  
24 the same document. I just have two copies.

25 Petitioner's motion for leave to disclose

1 Mountain States' highly confidential documents to  
2 individuals subject to the protective order and  
3 memorandum in support thereof was filed on June 10th,  
4 2015.

5 Mountain States' response to Petitioner's  
6 motion for leave to disclose highly confidential  
7 documents was filed on June 18th, 2015. Petitioner's  
8 reply memorandum regarding its motion for leave to  
9 disclose Mountain States' highly confidential  
10 documents was filed on June 22nd, 2015.

11 Orders entered by me on July 2nd, 2015.  
12 Order granting Mountain States' motion for continuance  
13 and to amend the scheduling order was filed on  
14 July 20th, 2015, in APD, and it has a stamped  
15 file date of June 30th, 2015, from the Agency.

16 Amended scheduling order was filed --  
17 rather was entered on July 22nd, 2015. The agreed  
18 protective order, which we alluded to earlier, was  
19 filed on July 20th, 2015.

20 I believe, Mr. Swearingen, you said it  
21 had a stamped date with the Agency of --

22 MR. SWEARINGEN: November 20th, 2014,  
23 Your Honor.

24 THE COURT: Thank you. Applicant's  
25 pre-hearing memorandum of law filed on July 20th,

1 2015. Mountain States Health Alliance's pretrial  
2 briefs filed on July 20th, 2015. Mountain States  
3 Health Alliance's notice of intent to introduce  
4 affidavit as well as the affidavit of Teresa Kidd  
5 was filed on July 20th, 2015.

6 Mountain States' motion in limine  
7 Number 1 to preclude evidence of potential  
8 Wellmont-Mountain States merger was filed on  
9 July 20th, 2015. Mountain States' motion in limine  
10 Number 2 to preclude letters of support in opposition  
11 was filed on July 20th, 2015. Mountain States' notice  
12 of intent to introduce affidavit and the affidavit of  
13 Karl Goodkin was filed on July 20th, 2015.

14 A letter to me from Mr. Christoffersen  
15 was filed on July 23rd, 2015, indicating that the  
16 Agency would not be filing a pretrial brief. Mountain  
17 States' witness and exhibit list was filed on  
18 July 24th, 2015.

19 SBH's memorandum in opposition to  
20 Mountain States' motion in limine Number 1 was filed  
21 on July 24th, 2015. SBH's memorandum in opposition to  
22 Mountain States' motion in limine Number 2 was filed  
23 on July 24th, 2015.

24 Counsel, is there anything that I did not  
25 list?

1 MR. SWEARINGEN: That's all we have, Your  
2 Honor.

3 MR. WEST: Your Honor, this is Bill West.  
4 I have a question. On the petition to intervene, has  
5 an order ever been issued on that?

6 MR. SWEARINGEN: There was an order  
7 entered by Your Honor on August 4th.

8 THE COURT: Right. There's an order on  
9 August 4th, Mr. West, that addresses that.

10 MR. WEST: All right.

11 THE COURT: August 4th last year.

12 Counsel, do you-all want the rule in  
13 effect for this matter?

14 MR. WEST: Yes, we do, Your Honor.

15 MR. JACKSON: Yes, Your Honor. I assume  
16 both of us will agree that expert witnesses can sit in  
17 as Mr. Sullivan, I see, is here, and Dr. Collier will  
18 be here later.

19 MR. WEST: That's fine with us, Your  
20 Honor.

21 THE COURT: And then your client  
22 representative, is that Ms. McDermott?

23 MR. JACKSON: McDevitt.

24 THE COURT: I'm sorry.

25 MR. WEST: Your Honor, if I may, I forgot

1 to introduce Mr. Shaheen, James Shaheen. He's the  
2 president of Strategic Behavioral Health. He'll be  
3 the party representative at least for today. And we  
4 have an employee who's with us in the courtroom today,  
5 but he will not be a witness.

6 MR. JACKSON: And, Your Honor, with  
7 respect to -- just so we're clear on the front end,  
8 we would object to any change of corporate witness.  
9 He said "for today." I don't think it's permissible  
10 to sort of circumvent the rule by switching out the  
11 representatives on a daily basis. We believe that  
12 both sides should have a corporate representative  
13 who's the same for the trial.

14 THE COURT: Well, is there an issue with  
15 his availability, Mr. West?

16 MR. WEST: Your Honor, I believe he plans  
17 to be here for the duration, but just as president of  
18 the company, there may be something unforeseen that  
19 might arise. That is why I made that comment.

20 THE COURT: Where he has to step out or  
21 go out?

22 MR. WEST: Has to step out, yes.

23 THE COURT: Certainly. All right. And I  
24 would ask that counsel, you-all -- I obviously don't  
25 know who the experts are. When people come in and out

1 of the room, I would ask for you-all to -- in terms of  
2 enforcing the rule or letting me know, sort of control  
3 that because you-all know who the experts are. And if  
4 you're agreeing that they can be present, if someone  
5 comes in, I won't know if they're a witness or an  
6 expert. So you'll have to keep an eye on that for me.

7 All right. The motions in limine. The  
8 first motion was Mountain States' motion to preclude  
9 evidence of a potential Wellmont-Mountain States  
10 merger.

11 MR. SWEARINGEN: Your Honor, that was our  
12 motion. And I read Mr. West's lengthy response, and I  
13 think we're maybe two ships passing in the night here.  
14 We never contended that we were attempting to exclude  
15 reference to statements made by Mr. Alan Levine, who  
16 is the CEO of Mountain States. He's going to be here  
17 to testify this week and is going to be happy to  
18 explain to Your Honor what he believes to be the needs  
19 of the psychiatric community in Upper East Tennessee.

20 What we were trying to avoid, though, was  
21 testimony regarding the potential of the merger itself  
22 between Wellmont and Mountain States as we set forth  
23 in our motion. It's highly speculative at this point  
24 to try to guess at what that merger -- if it does  
25 occur down the road, what it will look like from a

1 system perspective. And we were trying to avoid  
2 arguments such as, you know, if that merger were to  
3 take place someday, that would limit competition in  
4 the community or something along those lines. I think  
5 it would be a little bit of a red herring for us to  
6 get into all that. But that was the limited purpose  
7 of that motion.

8 I think Mr. West, the entirety of his  
9 response related to these statements by Mr. Levine.  
10 And those are statements by an individual who will be  
11 here to testify, and he can be cross-examined on those  
12 statements and he can explain to the Court what he  
13 meant by them.

14 MR. WEST: Your Honor, I appreciate  
15 Mr. Swearingen's clarification, and it's not our  
16 intent or our plan to delve into the details of the  
17 actual merger, but if I can take a moment and describe  
18 to the Court what's involved in this process and why  
19 it has become controversial.

20 Mountain States and Wellmont, as is  
21 public knowledge, plan to enter into negotiations  
22 as Mr. Swearingen referenced. And because they are  
23 the largest health care systems in that part of the  
24 country, normally there would be antitrust concerns,  
25 federal antitrust laws, but if the states -- or, in

1 this particular case, Tennessee -- actively regulate  
2 what they do or the end result or the process, then  
3 there's state action immunity from the antitrust laws  
4 as a matter of federalism.

5 The Supreme Court has said states have  
6 the right -- states have the natural and inherent  
7 rights to regulate their trade, and so if they do  
8 that, then the concerns expressed in the Sherman Act  
9 or any other federal antitrust act are met.

10 So a lot of the publicity has been  
11 about and what we address in our brief is -- the  
12 process that the state has set up through the  
13 statutory changes enacted by the General Assembly  
14 this year have to do with the Certificate of Public  
15 Advantage statute which was passed in the mid '90s.  
16 It was very quiescent.

17 And this year, I think it's public  
18 knowledge, at the behest of both Mountain States and  
19 Wellmont and other leaders in East Tennessee, it has  
20 been significantly altered to make it a more detailed  
21 process.

22 And so there's been a lot of publicity  
23 about it, there's been a lot of statements about it,  
24 and the line between talking about the COPA, the  
25 Certificate of Public Advantage, and the merger, which

1 is going to happen at the end, if everything goes  
2 right, is very indistinct. And so I think it's  
3 inappropriate -- or it's not appropriate to limit  
4 on the front end any mention at all of the merger,  
5 because if you talk about the COPA, which we have to  
6 talk about, you're essentially talking about the  
7 potential for the merger.

8 That being the case, if we ask any  
9 questions that are untoward or aimed -- we don't  
10 intend to, but aimed at the details of the merger  
11 which haven't been worked out, as we acknowledge, then  
12 objections can be made, and I think the Court will  
13 certainly handle those.

14 But to say on the front end, well, you  
15 can't even mention the word "merger" when, in fact,  
16 the whole COPA process which has been the subject of  
17 all this publicity is aimed at generating a merger, if  
18 possible, subject to state regulation, that would be  
19 permissible under all the applicable state and federal  
20 laws.

21 So what disturbed us about the motion was  
22 this broad sweep to say you can never mention it. And  
23 it's impossible to talk -- we have to talk about the  
24 COPA process and the COPA regulations because they  
25 mention Certificate of Need laws.

1           For example, in those regulations that  
2 we cite, which were just filed with the Secretary of  
3 State's office just a few weeks ago, a couple of weeks  
4 ago, the Department of Health and Regulations say one  
5 of the things you have -- as a COPA participant, when  
6 they get together and they finally get everything  
7 lined up to file with the state, one of the things  
8 they have to list is the number of Certificates of  
9 Need that will be necessary to carry out what the COPA  
10 wants to. And that's a new development as far as I  
11 know, but it's in those regulations that just were  
12 issued.

13           So, in that sense, COPA and CON are  
14 related and -- because COPA itself has to do with  
15 merger issues. In the abstract, at the front end, I  
16 just don't think it's -- I think it's inappropriate to  
17 put a bright line down and say you cannot mention the  
18 word "merger." It's going to come out if you talk  
19 about the COPA.

20           And we have to talk about the COPA,  
21 Certificate of Public Advantage, publicity and  
22 commentary and so forth because that's vitally  
23 important to this process that we're in today.

24           And that's why we addressed the comments  
25 by Mr. Levine because that's the clearest indication

1 of their direct relevance to the CON process. But,  
2 again, we would say it is conceivable that we might  
3 ask a question that -- not intentionally, at this  
4 point -- that something came up and the merger context  
5 might have been raised.

6 But on the front end, I think it's  
7 highly inappropriate to limit that, given the fact  
8 that Mountain States itself has publicized the COPA,  
9 has actually publicized the fact that they're talking  
10 about some kind of merger with Wellmont, and Wellmont  
11 has done the same thing. And that's part of the  
12 process that they engaged in at the legislature when  
13 they got the COPA statute changed.

14 So, in any event, that's our position,  
15 and we'll be happy to answer any questions you may  
16 have about it.

17 THE COURT: Mr. Christoffersen, if at any  
18 moment -- where you're situated, I may -- while the  
19 attorneys for the petitioner and intervenor obviously  
20 will probably have more questions of witnesses and  
21 more argument, but if you need to, jump in. And if,  
22 for some reason, any of us sort of overlook you --

23 MR. CHRISTOFFERSEN: Thank you, Your  
24 Honor.

25 THE COURT: So feel free to do that.

1 MR. CHRISTOFFERSEN: I would just simply  
2 add, with respect to this motion, that -- or would  
3 suggest that you look at two things. One is, we can  
4 have a fascinating discussion about the merger, but  
5 to what extent does anything pertaining to the merger  
6 relate to whether the applicant's project satisfies  
7 need, economic feasibility or contribution to the  
8 orderly development of health care? Of course, sight  
9 unseen or question unseen, it's hard to know that  
10 right now, but that's what I would suggest bearing in  
11 mind.

12 Then the other thing, of course, is  
13 we know what we know about the merger, but at the  
14 beginning of the process or at this early stage of the  
15 process, there's an awful lot that we don't know about  
16 what it's going to look like on the other end or what  
17 any of the services of the combined or surviving  
18 entity's going to look at or if the merger even works,  
19 even ends up happening. So I would suggest those  
20 things be kept in mind.

21 THE COURT: Thank you.

22 Do you have anything further?

23 MR. SWEARINGEN: Mr. Christoffersen said  
24 it better than I could, Your Honor.

25 THE COURT: I think in this instance I'm

1 going to reserve any ruling and just as matters come  
2 up -- I think the Mountain States counsel indicated  
3 the issue about need, and you addressed that in detail  
4 in your response, Mr. West, that I don't believe they  
5 intended that to be something that was going to be off  
6 the table, and that was something that I would have  
7 said could be discussed.

8           And as far as other matters, we'll just  
9 have to see as it arises. Certainly, it's a proposed  
10 merger, and there may be limits about testimony, but I  
11 think I'll just have to take it up if it becomes an  
12 issue in the actual hearing.

13           MR. WEST: Thank you, Your Honor.

14           THE COURT: All right. The second motion  
15 regarding the letters?

16           MR. JACKSON: Yes, Your Honor. The  
17 motion in limine Number 2, Mountain States Health  
18 Alliance has moved to exclude certain letters that  
19 were written by third parties that were submitted  
20 to the Agency at the time the CON application was  
21 originally considered. And in the same category of  
22 information, we would also include the transcript of  
23 proceedings before the Agency where various people  
24 made statements about the application.

25           And the reason that these materials

1 should be excluded are severalfold. First of all, of  
2 course, this is a de novo proceeding. What happened  
3 before the Agency is not relevant to what we're here  
4 about today, except insofar as the burden of proof was  
5 established by the agency's action.

6 In this case, the CON being denied places  
7 the burden, of course, on the petitioner. And that  
8 fact of the vote will be established through the  
9 minutes of the Agency proceeding which we've all  
10 agreed can be entered into our record here.

11 But other than that, the proceedings  
12 below, if you will, or in the Agency, if you will, in  
13 the first hearing or first meeting concerning this  
14 matter are not relevant to what we're doing here  
15 today.

16 Secondly, of course, all of these  
17 materials are hearsay. I mean, they're out-of-court  
18 statements. These people are not available to us  
19 here to cross-examine about the statements, and none  
20 of the statements, either in the letters or in the  
21 transcript, were made under oath; therefore, they  
22 shouldn't be allowed into this proceeding, because it  
23 puts us at a great disadvantage if people are allowed  
24 to come into this case through letters or through  
25 statements they made at the public meeting and they

1 can't be subject to cross-examination about those  
2 statements, because, of course, at the meeting there's  
3 no opportunity to cross-examine, and you can't  
4 cross-examine someone who writes a letter.

5           And we would submit that in some cases  
6 these letters contain statements that if the author  
7 was subject to cross-examination, the statements would  
8 be found to be false or not entirely accurate and not  
9 reliable.

10           And, Your Honor, I've got a -- I haven't  
11 always objected to this material, and I'm happy to  
12 share with the Court why I believe it's important  
13 that I object to the material in this case and that  
14 the Court exclude this material, because in my own  
15 experience in a recent case, the Covenant ETRTS case  
16 before Judge Stovall, somehow some letters of support  
17 got slipped into the record probably because they were  
18 part of the Agency package, what the Agency members  
19 received. Nobody ever mentioned those letters.  
20 Nobody talked about them during the entire week-long  
21 trial we had in this very courtroom. Judge Stovall,  
22 when he entered an order denying the CON, didn't refer  
23 to any of these letters.

24           Well, the other side appealed back to the  
25 Agency and asked the Agency to reverse Judge Stovall's

1 order, which the Agency did. That's subsequently  
2 been reversed by the chancery court. But the Agency  
3 reversed Judge Stovall's order, and, in doing so, they  
4 adopted the suggestions of the petitioner to insert  
5 into the final order of the case all this stuff from  
6 these letters that nobody had ever mentioned, that had  
7 never been relied on by the judge, that had never been  
8 discussed.

9           And so somehow, at the end of the day,  
10 the final order of the Agency contained several  
11 paragraphs that related to these letters of support  
12 by people who weren't under oath, who I never had the  
13 chance to cross-examine, and there they were in the  
14 final order of the Agency. Again, it was reversed,  
15 ultimately, by the chancery court. That's now in the  
16 appellate courts.

17           So based on that experience, I'm hyper  
18 attuned, if you will, to the risk of allowing this  
19 sort of material to just be inserted into our record  
20 here, because down the road I don't want these  
21 statements being used and inserted into an order when,  
22 in fact, they're not accurate, in some instances, and  
23 the people haven't been put under oath and called to  
24 testify.

25           Anybody who wrote a letter of support or

1 who spoke before the Agency could have been brought  
2 here, subpoenaed here to testify by either of the  
3 parties or had an affidavit prepared and submitted  
4 under the UAPA as we did with two witnesses.

5 So there's no reason to allow either the  
6 transcript or the letters into our record, given that  
7 we've had ample time to collect evidence the proper  
8 way and put people under oath.

9 Thank you.

10 MR. WEST: Your Honor, if I may respond  
11 to Mr. Jackson's statement -- arguments. The Rules of  
12 Evidence do not, in our view, according to the cases  
13 that we cite, apply directly to these proceedings  
14 unless they're invoked by the Agency itself. And  
15 my understanding of the Agency rules is they do not  
16 require the Rules of Evidence to be complied with.

17 And if you look at the Secretary of  
18 State's rules, they refer, on the evidentiary  
19 questions, to TCA 4-5-313, which says in Subpart 1  
20 that "The Agency shall admit and give probative effect  
21 to evidence admissible in a court and when necessary  
22 to ascertain facts not reasonably susceptible to proof  
23 under the rules of court. Evidence not admissible  
24 thereunder may be admitted if it is of a type commonly  
25 relied upon by reasonably prudent men in the conduct

1 of their affairs."

2           The reason I cite this is because all of  
3 us who have practiced in front of Mr. Christoffersen's  
4 agency, the HSDA, know that when the Agency receives a  
5 Certificate of Need or -- here's the process that the  
6 Agency goes through: receives a Certificate of Need  
7 and various reports from the state, and two to  
8 three weeks before the hearing, it ships them out and  
9 posts them online for its members to look at. And  
10 that package is called the mail-out package.

11           And in the mail-out package, the Agency  
12 includes letters of support and opposition that it has  
13 received so that the members of the Agency can examine  
14 them. And on many, many cases, Agency members will  
15 cite letters of opposition or support in their  
16 comments at the hearing; they will utilize the  
17 letters.

18           And so I think you can see in this case  
19 there are letters that were submitted in support and  
20 in opposition, and in the actual mail-out, they were  
21 included with the application. They're part of the  
22 Agency records subject to anyone's investigation or  
23 review. And, in fact, that package was made an  
24 exhibit to one of the depositions in this matter by  
25 opposing counsel.

1           So given that, I think that this tribunal  
2 can say that those letters should be admissible. They  
3 should be reviewable by this court, by this tribunal,  
4 and they should stay in the record. They're part of  
5 the Agency record. They're available for public  
6 inspection, and the Agency relies on them, many times,  
7 in reaching its decisions.

8           The other comments I wanted to make were  
9 about the transcript of the proceedings, because I  
10 think it's important to note that in the transcript  
11 of the proceedings, a number of speakers, such as  
12 Mr. Shaheen and Ms. Bailey, who, I think, is supposed  
13 to be a witness here for the other side, spoke at  
14 length.

15           So the transcript itself should not  
16 be -- even if this tribunal decides to exclude other  
17 witnesses, the examinable witnesses who spoke at the  
18 hearing, we should be able to use the transcript  
19 context, text, to cross-examine them here before Your  
20 Honor. And I think we have probably done that -- I  
21 can't recall the exact ones, but both sides have had  
22 access to the transcript and we've used it in  
23 depositions, I'm sure.

24           And so it's important -- and that is a  
25 part of the Agency file. I mean, the Agency has that

1 transcript. The Agency always records -- it records  
2 its proceedings on tape and it has a transcript  
3 prepared or preparable [sic], and so those are public  
4 records subject to the Agency's practice and control.

5 So given that, I think even if Your Honor  
6 decides that witnesses who spoke who aren't here, that  
7 may be excludable -- although I think, just as I said  
8 earlier, the Agency relied on their statements in  
9 making its decision, so from that standpoint, I think  
10 those are admissible also. But at a minimum, the  
11 people who spoke, who are reviewable here in court,  
12 cross-examinable, that evidence should be available  
13 to lawyers for both sides -- or all three sides to  
14 cross-examine the witnesses with. Actually, I think  
15 it would be inappropriate to totally prohibit that.

16 And the other point I would make, again,  
17 much as you did with the first motion, is it may be  
18 advisable to wait and see which records we're talking  
19 about here before Your Honor decides to exclude them  
20 or to make a decision on that point.

21 Thank you.

22 MR. CHRISTOFFERSEN: Well, it's  
23 interesting that after all these years, this is the  
24 first time we've actually had this argument about  
25 whether or not these letters and such can come in.

1 But Mr. Jackson's point is well-taken.

2 As counsel for the Agency, I feel that  
3 I'm in a bit of an unusual position, not only in this  
4 case, given the Agency's posture with the 4-4 vote,  
5 but also to the extent that both Mr. Jackson and  
6 Mr. West, I think, made some very good points this  
7 morning on this issue.

8 The Agency and the Agency's staff, at  
9 their direction, strive to make the Certificate of  
10 Need process a very open process and one in which  
11 community participation is encouraged, because, after  
12 all, the folks in the community are the ones who will  
13 be affected by the project and they're the ones who  
14 have needs and don't have needs.

15 I would hate, on the one hand, to see  
16 support that somebody's made the effort to send in a  
17 letter or to testify -- I won't use the word "testify"  
18 -- to appear and speak before the Agency for the  
19 extent to which its their support, I would hate to  
20 see that excluded.

21 On the other hand, these cases are not  
22 a beauty pageant. These applications aren't decided  
23 that way. Both the Agency and administrative judges  
24 sometimes rule in a way that the public support had  
25 urged; sometimes they go the other way. There's very

1 specific laws, rules, criteria in the State Health  
2 Plan that we'll speak about later that govern whether  
3 the application should be approved.

4           So while I would hate to see that support  
5 not included, at the same time, I would think that  
6 it's well-taken that as far as the truth of the  
7 matters asserted, beyond the fact that there is  
8 support, for example, "I support this project because"  
9 and here's what can be taken as testimony, that's  
10 something that perhaps should come in in the form of  
11 live testimony or an affidavit or what have you.

12           And Rules of Evidence and civil  
13 procedure, the types of things that apply in judicial  
14 and quasi judicial forums, are not applied before  
15 the Agency itself when anybody can just show up and  
16 say whatever, you're not sworn under oath and, as  
17 Mr. Jackson said, there's no opportunity for  
18 cross-examination unless a member has a question for  
19 you.

20           So the proceedings before the Agency and  
21 the proceeding before you and anything that may go  
22 above this level, different rules apply, in other  
23 words.

24           THE COURT: And let me just ask you. I  
25 was going to address this to Mr. West, but you may

1 know the answer to this.

2 And, Mr. West, you can respond if you  
3 want to.

4 The actual application that the Agency  
5 has that an applicant has to fill out, does it include  
6 a section for letters of support or any letters either  
7 way?

8 MR. CHRISTOFFERSEN: It doesn't include a  
9 section as much as parties traditionally submit them.  
10 Also, word gets out of applications and letters of  
11 opposition come in, and Agency staff compiles those  
12 and sends them to the Agency members. But reality,  
13 you don't really know whether the letter's even  
14 authentic, much less the truth of the matter asserted.  
15 However, the process works to the extent that it's  
16 done before the Agency because Agency members can ask  
17 questions about it, but -- and there's a reason why  
18 the UAPA provides for an affidavit, for example.

19 THE COURT: Right. And I thought that  
20 was the case, though. The application does not put a  
21 burden or requirement on the applicant to compile  
22 letters for or against a particular project. I  
23 understand it's done, but it's not required.

24 MR. CHRISTOFFERSEN: Yes, Your Honor.  
25 It's not required. And I would certainly see no harm

1 in acknowledging that there's a lot of public support  
2 for this project and there was a good deal of  
3 opposition to it as well. But as far as the reasons  
4 for that support and opposition, perhaps there are  
5 other ways to explore those.

6 THE COURT: Okay. Thank you.

7 Did you want to respond to that question,  
8 Mr. West?

9 MR. WEST: I did in a very limited way,  
10 Your Honor. It goes back to the point I made earlier.  
11 I think Mr. Christoffersen is right. One of the great  
12 things of the CON process run by the Agency is that  
13 it's totally open and totally public and anything that  
14 gets filed with the Agency is public. And the Agency  
15 encourages these kinds of submissions, and they are  
16 frequently packaged with the application or they may  
17 come in later.

18 But the point is, to totally prohibit  
19 any reference to them, for example, would eliminate  
20 what Mr. Christoffersen just, basically, said, that  
21 there was significant support for this application;  
22 there was significant opposition. And I think you can  
23 see that in the results of the vote. It was a 4-to-4  
24 tie.

25 So we certainly don't want to be limited

1 from referencing the fact that there were letters of  
2 support, for example, or that there were numerous  
3 letters of support, and our opponents can certainly  
4 reference that there were letters of opposition.

5 But if you determine not to admit them,  
6 we would like not to be restricted in that regard.  
7 As Mr. Christoffersen says, it's something that is a  
8 matter of public record and does not -- even if you  
9 apply the rules, as urged by Mr. Jackson, I think that  
10 aspect of it should not be limited.

11 Thank you.

12 THE COURT: Mr. Jackson, do you have a  
13 point you want to make?

14 MR. JACKSON: Very briefly. I neglected  
15 to mention there is case law that addresses this  
16 issue, which is the Rader versus Gruneau (phonetic)  
17 case, which makes it clear in dealing with this  
18 statute, 4-5-313, that the provision applies only to  
19 facts not reasonably susceptible to proof under the  
20 rules of court and does not permit substituting  
21 hearsay for the testimony of otherwise available  
22 witnesses.

23 So, in other words, while it's true  
24 that the hearsay rule is relaxed in administrative  
25 proceedings, it's not just wiped away. If it's a

1 witness who can be called -- and I can pass up a copy  
2 of the case for Your Honor.

3 THE COURT: I'm familiar with it.

4 MR. JACKSON: If there's a witness who  
5 can be called, there's no reason the witness shouldn't  
6 be called rather than going with the hearsay.

7 And with respect to the transcript, I  
8 suggest we cross that bridge when we come to it. If  
9 there's a witness that testifies inconsistent with  
10 their statements before the Agency, I don't agree that  
11 that transcript could be used to impeach them, but, I  
12 mean, rather than waste time arguing about that now,  
13 let's see if that actually happens. If someone gives  
14 inconsistent testimony and Mr. West wants to impeach  
15 them, I guess we can cross that bridge then. I don't  
16 think it's a sworn statement.

17 If you look at the rule on impeachment,  
18 you know, a statement that's not under oath is not  
19 typically admissible to impeach a witness, as I recall  
20 the rule. But I don't think we're going to have  
21 anyone that's going to say anything inconsistent with  
22 what they said, so it's probably an academic exercise.

23 THE COURT: As to the transcript, that  
24 really wasn't part of the motion, I don't think. You  
25 sort of added that in in your response, Mr. West. And

1 I think perhaps we'll cross that bridge if we come to  
2 it.

3 Of course, any witness, you've got the  
4 Rules of Evidence 613 for prior inconsistent statement  
5 that's available to you. And so if you have a  
6 situation where one of your -- anyone's witness is  
7 testifying and you think it's inconsistent from a  
8 prior statement, I think you can avail yourself to  
9 Rule 613.

10 As far as the letters for and against,  
11 it doesn't appear from the argument that that's part  
12 of the application. The rules for the Agency,  
13 specifically Rule 0720-113-0.2(3), speaks to, at  
14 the beginning of this hearing, which I'll get to in  
15 just a moment with Mr. Christoffersen, that the Agency  
16 counsel provides a summary of what the case is about,  
17 description of the project and introduce into evidence  
18 the application, reviewing agency's report, and the  
19 staff summary, as well as the minutes of the Agency  
20 reflecting any actions taken before the Agency.

21 Now, of course, there's a prelude to that  
22 statement that says "unless otherwise agreed to by the  
23 parties." So you-all may have agreed to something  
24 else. Certainly you haven't agreed to these letters.  
25 But the language of that rule itself doesn't say

1 anything about the letters.

2 It does mention application, but I think  
3 we've established that the letters are not part of the  
4 application itself. I think there's some evidentiary  
5 concerns that have been raised by Mountain States of  
6 admitting the letters. So my ruling is the letters  
7 won't be admitted.

8 Now, Mr. West, if there's -- and for the  
9 reasons I just gave. However, if -- and there may be  
10 a situation -- and I don't know this, of course, but  
11 there may be a witness who wrote one of these letters  
12 and you can somehow get in and satisfy the Rules of  
13 Evidence. So I'm not going to just say, blanket, none  
14 of them can come in. If there's some way that you can  
15 satisfy the rules, then I'll take that up.

16 I know in other cases a box is rolled  
17 in, or two boxes or three, and they have "for" and  
18 "against." And so I would say that that would not be  
19 admitted in this instance.

20 MR. WEST: Thank you, Your Honor.

21 THE COURT: All right. Are there any  
22 other preliminary matters, counsel, before we move on?

23 MR. JACKSON: Nothing on behalf of  
24 Mountain States.

25 THE COURT: All right. And,

1 Mr. Christoffersen -- I just read that statute.

2 And so have you-all agreed to something  
3 otherwise, or does Mr. Christoffersen have the stage  
4 at this time to speak pursuant to his Agency's rule?

5 MR. CHRISTOFFERSEN: Well, I would say  
6 that we have agreed to the extent as far as how the  
7 documents are going to come into evidence. That's  
8 something that Mr. West and Mr. Swearingen have  
9 primarily worked out and will be found in the  
10 notebooks that everybody has a copy of.

11 THE COURT: And I have two notebooks up  
12 here. Are you referring to those notebooks also?

13 MR. SWEARINGEN: Your Honor, I think  
14 that is what Mr. Christoffersen is referencing. And  
15 I think, based on your ruling, maybe what we'll do is  
16 bring in tomorrow morning a full copy of -- I think  
17 all the parties are in agreement that the application,  
18 the minutes, the Agency summary will be -- pursuant to  
19 the rule will be -- and we'll make it Exhibit 100.

20 Mr. West, is that agreeable?

21 MR. WEST: That's fine with me, Your  
22 Honor, given Your Honor's ruling, but the problem  
23 is -- like, for example, with Mr. Shaheen today,  
24 we were planning to use Exhibit Number 9 in this  
25 notebook, and it's the one that was made an exhibit

1 to Mr. Garone's deposition by Mr. Swearingen, and it  
2 has letters of support in it.

3 And I apologize to Your Honor for not  
4 working this out with Mr. Swearingen ahead of time,  
5 but we were under the press of a lot of other  
6 paperwork too.

7 So it will complicate our presentation  
8 to some extent, but, I mean, everybody has copies of  
9 Number 9. We could go forward with it today and then  
10 replace -- you see how awkward it becomes, because  
11 then we have to replace references in the record to  
12 the exhibits and so forth.

13 MR. SWEARINGEN: We can just change out  
14 Number 9 tomorrow to include the items that were  
15 enumerated in the rule and then make that Number 9.

16 MR. WEST: That would be a good result,  
17 and that way I can go ahead and examine Mr. Shaheen on  
18 the contents of the application itself.

19 MR. SWEARINGEN: And that would be Tab 9,  
20 which is in the notebook that you have in front of  
21 you, Judge.

22 THE COURT: And so Tab 9 covers what's in  
23 the Rule 0720-13-.02(3)?

24 MR. SWEARINGEN: It does not have the  
25 minutes. It was just a copy of the Agency packet. So

1 it has more than the rule specifies. And so I think  
2 what we'll do is we'll just -- starting tomorrow  
3 morning, we'll replace Number 9 in everyone's  
4 notebooks so that it's consistent with what the rule  
5 requires -- or asks for, which is the minutes, the  
6 Agency summary, the Department of Mental Health  
7 summary, and the application.

8 MR. WEST: That's acceptable, Your Honor.  
9 As I said, though, it may complicate the paperwork  
10 flow today with Mr. Shaheen, but we'll deal with that  
11 as it comes up.

12 THE COURT: So, Mr. Christoffersen, does  
13 that affect what you need to say pursuant to the rule,  
14 or is that --

15 MR. CHRISTOFFERSEN: That as well as just  
16 to briefly state what the case is about and quickly  
17 what my role is and isn't before I, hopefully, let the  
18 parties have their chance to have their day in court.

19 THE COURT: All right. We'll do that  
20 and then I'll let the parties give their opening  
21 statements.

22 MR. CHRISTOFFERSEN: Good morning, Your  
23 Honor. I'm Jim Christoffersen, again, counsel for  
24 the Health Services and Development Agency. In this  
25 particular case, I have an even more unusual role than

1 usual in that the vote before the Agency, as will be  
2 shown in the minutes, as the parties, I'm sure, agree,  
3 was a tie vote of 4 to 4; therefore, the motion to  
4 approve the application that was made failed because  
5 you have to have a majority of Agency members present  
6 and voting in order for an application to be approved  
7 or for the motion vote to be passed.

8           Given that case, the burden of proof has  
9 been set. It remains upon the applicant. However,  
10 given the nature of the vote, the four members in  
11 favor, four members opposed to the application, Agency  
12 staff and, therefore, Agency counsel don't feel that  
13 we have been given a mandate by the Agency to take a  
14 position as to whether or not this application should  
15 be approved or denied.

16           And I don't mean to imply anything by  
17 saying that, as far as what your task is or what the  
18 task is of the other parties today. I just wanted to  
19 make clear what I'm going to be doing here or not  
20 doing here as well.

21           That having been said, the Agency and,  
22 therefore, the staff of the Agency acting on its  
23 behalf does have a role and does have an interest in  
24 the process itself, though, making sure that both of  
25 these parties have a fair shot at making their case

1 and that the process itself flow as it should, work as  
2 it should, and also questions of law, the rules, the  
3 guidelines, and evidence that may arise as well.

4 Quite often, when arguments are made by  
5 Mr. Jackson, Mr. West, Mr. Swearingen, I may not have  
6 anything to add, but there may be some times, and as  
7 you'd indicated earlier, I'll try and let you know  
8 when I feel that something should be added on behalf  
9 of the Agency itself.

10 What the case before us is, is whether or  
11 not Certificate of Need application 1312-050 submitted  
12 by SBH-Kingsport, LLC, should be approved or denied.  
13 This, of course, is a trial de novo. This is not an  
14 appellate proceeding about what the Agency did below.  
15 As had been pointed out by Mr. Jackson, that just set  
16 the burden of proof and that's really all.

17 This is an application for the  
18 establishment of a new 72-bed freestanding mental  
19 health hospital and the initiation of inpatient  
20 psychiatric services in Kingsport, Tennessee. Since  
21 Mr. West and Mr. Jackson will tell you what each party  
22 feels the issues are in this case, I will not belabor  
23 the point by doing so for you right now.

24 What I will point out, though, is that  
25 the governing law in this case is Tennessee Code

1 Section 68-11-1609(b), and that is where what we refer  
2 to, in simple terms, as need, economic feasibility,  
3 and contribution to the orderly development of health  
4 care are spelled out in the statute. It goes on to  
5 say that "In making the determination of whether those  
6 three elements have been satisfied, the Agency shall  
7 apply the guidelines from the State Health Plan."

8 And that's where the analysis of every  
9 application should begin. It should begin there. The  
10 rules do go on, though, to say that other things may  
11 be looked at, as spelled out in the Agency's rules  
12 which Mr. West had attached to his pretrial brief, if  
13 I'm not mistaken, which are in Chapter 11 of 0720,  
14 which is the Agency's section of rules.

15 But as you may also recall, Your Honor,  
16 from the Spring Hill case that you sat for, and I'm  
17 sure you're familiar with the order that was handed  
18 down from the chancery court, there are situations in  
19 which even if whatever numeric or other matters for  
20 consideration are spelled out in the guidelines may  
21 not technically be satisfied, you may look at the  
22 other things spelled out in the Agency's rules, but  
23 in order to approve an application, it has to be more  
24 than just something thrown out there as a good reason.  
25 There has to be a strong reason to look beyond the

1 guidelines.

2           And I'll be here and happy to answer any  
3 questions and chime in on any arguments, but otherwise  
4 I'll just try to stay out of the parties' way as they  
5 each have their say in court.

6           Thank you, Judge.

7           THE COURT: Thank you,  
8 Mr. Christoffersen.

9           Mr. West?

10           MR. WEST: Thank you, Your Honor. Again,  
11 I'm Bill West here on behalf of the applicant. If the  
12 Court will indulge me for just a minute or two to get  
13 adjusted here to my task.

14           As Mr. Christoffersen indicated,  
15 this is an application by an entity related to  
16 SBH-Kingsport, LLC, as related to Strategic Behavioral  
17 Health, Inc., which is a private psychiatric hospital  
18 company that's based in Memphis, and they've been in  
19 business for a number of years and they currently  
20 operate, I think it's about eight psychiatric  
21 facilities around the country, primarily in North  
22 Carolina, Texas, Colorado and Nevada. This will be  
23 their first Tennessee project. Mr. Shaheen is their  
24 president, and he's here today.

25           Through their processes, they have

1 designated the Northeast Tennessee area and  
2 specifically Kingsport as the location of their  
3 hospital. It will be based in Kingsport in Sullivan  
4 County and will serve, as the CON application will  
5 show, a five-county service area: Sullivan and  
6 Hawkins in Tennessee, and then Wise, Scott, and Lee  
7 counties in Southwest Virginia which are just across  
8 the Virginia line, at least the lower one is just  
9 across the Virginia line, from Sullivan County.

10           And so what's unusual about this case --  
11 there's a number of things that are unusual about the  
12 case, but Sullivan County did have a psychiatric  
13 hospital in it until 2009, Indian Path Pavilion.  
14 Mountain States owned Indian Path Pavilion, and they  
15 closed it down, causing a net loss of 52 psychiatric  
16 hospital beds. Now, it actually had 61, but nine of  
17 those were moved to the Woodridge Psychiatric Hospital  
18 in Johnson City, another -- a service of Johnson City  
19 Medical Center.

20           And so, given that, that loss was  
21 indicative of a larger loss of psychiatric beds in  
22 East Tennessee. For example, in 2012, the state  
23 closed down, I think it was called Lakeshore Mental  
24 Health Institute in Knoxville. It was licensed for a  
25 capacity of 250 beds, and it had Sullivan and Hawkins

1 County in its catchment area. So those beds  
2 disappeared in 2012. Other psychiatric bed losses  
3 have occurred.

4 And so you have this general exit of  
5 psychiatric beds all across the state, not just in  
6 Upper East Tennessee but especially in Upper East  
7 Tennessee, and so it is a logical place to put a new  
8 psychiatric hospital, especially in Sullivan County.

9 The HSDA, I think, has recognized that  
10 something needs to happen to build the bed inventory  
11 back up for psychiatric hospitals. It has recently  
12 approved significant psychiatric hospital projects  
13 in Memphis, in Shelby County, and Madison County and  
14 Rutherford County and Williamson County as well as  
15 smaller general psychiatric units, smaller units of  
16 just a few beds in Huntingdon, for example, in West  
17 Tennessee. But none of those projects have reached up  
18 into Upper East Tennessee, and so Upper East Tennessee  
19 still has an unmet need for additional psychiatric  
20 hospital beds.

21 And one of the things that we looked at,  
22 which is, frankly, really surprising even to us, last  
23 week or so, the last batch of discovery updating came  
24 over to us from the Mountain States' attorneys, and we  
25 looked at the -- one of the things we'd asked them

1 about was their daily census. They have a daily  
2 census report. I think it's called Patient Flow  
3 Sheet. And it lists on there the number of beds  
4 available at 8:00 in the morning and then it has  
5 different units and it describes -- and there were  
6 people on the waiting list and so forth.

7           But just taking the occupancy rates that  
8 it lists -- it has 84 beds, and so I did a little  
9 analysis. You'll hear more about this in the proof.  
10 In March, on 21 days in March of 2015, its occupancy  
11 rate was over 90 percent. On ten of those days, it  
12 was over 95 percent. In April 2015, 20 days were over  
13 90 percent, and nine days were over 95 percent. In  
14 May, they had 25 days over 90 percent, and 12 days  
15 over 95. And in May, they actually hit, according to  
16 their own data, 98.8 percent occupancy. They're  
17 basically full. And then in June there were 21 days  
18 over 90 percent and only six days over 95 percent.

19           And this is a trend. This is not just  
20 a four-month blip. The utilization at Woodridge has  
21 been trending up for a year and a half now, and to us  
22 that's a sign of need. And you say, well, what impact  
23 does it have on Sullivan County? Well, we also asked  
24 them for -- there's a concept in psychiatric hospital  
25 care called deferrals, and as I understand it, that's

1 when a patient presents to the hospital but the  
2 hospital can't take him. Maybe he's got a problem  
3 they can't handle, maybe he's -- maybe he's got some  
4 comorbid situation with a known disease, but also if  
5 the hospital doesn't have beds, they have to defer him  
6 somewhere else.

7 So from January '15 to May 2015, there  
8 were 76 adult deferrals of people in Sullivan County  
9 who couldn't get into Woodridge. And they have no  
10 hospital in Sullivan County, so they can't go there.  
11 There were another 17 people from Hawkins County.  
12 And that was in the adults. And the adolescents,  
13 similarly, the biggest -- the county with the most  
14 adolescent deferrals was Sullivan County. There were  
15 ten of those. And Hawkins County had two.

16 So you say, well, that's just a few  
17 patients. Well, over a year's time, it's hundreds of  
18 patients, and that's just from Sullivan and Hawkins.  
19 We didn't track -- I don't think we have data for the  
20 Virginia counties.

21 But the point I'm making is that backdrop  
22 of the impact on Sullivan County, when you put it up  
23 against the 95 to -- 90 to 95 to 98 percent occupancy  
24 that their facility, Woodridge, has, there's clearly  
25 a need. I mean, we have the three criteria: need,

1 economic feasibility, and contribution to orderly  
2 development. That need is the main criterion. And  
3 that clearly is a sign of need in Sullivan County and  
4 Hawkins County for inpatient psychiatric beds.

5 And so the unique thing about Woodridge  
6 is, the Woodridge Psychiatric Hospital, which is a  
7 satellite of Johnson City Medical Center in Johnson  
8 City, it's the only significant supply of inpatient  
9 psychiatric hospital beds in East Tennessee, really  
10 north of Knoxville, and it's the only full-range  
11 psychiatric hospital in that area.

12 Now, there are 12 psychiatric hospital  
13 beds in Sullivan County, but they're over in Bristol,  
14 at the far end of Sullivlan -- east end of Sullivan  
15 County. So there are 12 beds up there, but those 12  
16 beds have been 65 to 70 percent full, according to our  
17 data. So there's not much place for them to go. So  
18 you've got the 12 beds in Sullivan County and no beds  
19 in Kingsport anymore, unlike the situation in 2009 and  
20 prior.

21 So, you know, it's vitally important  
22 in this analysis of our CON application for us, as  
23 the applicant, to keep this in mind, also for this  
24 tribunal. When we began this process, the story  
25 was -- the arguments were, a year ago, that with all

1 these vacancies at Woodridge, a psychiatric hospital  
2 in Johnson City -- well, that's -- it might have been  
3 true at some point in the past, but it hasn't been  
4 true for at least a year and a half.

5 Their annual rate for this fiscal year,  
6 as we figure it, is approximately 85.2 percent, and  
7 that goes from July 1 to June 30th, 2015, from '14 to  
8 '15. And that's the highest I've seen it recorded,  
9 but it's been steadily climbing for years. And it's  
10 really gotten much higher recently.

11 And the other thing to remember, and I  
12 learned this in dealing with this case, is that a  
13 hospital may have 84 beds or, like ours, 72 beds, but  
14 that's not a true measure of its availability because  
15 -- and both of these -- in the existing Woodridge and  
16 in our proposed project, the hospitals have or will  
17 have double-occupancy rooms, two patients to a room.  
18 And Woodridge, for example, has a child and adolescent  
19 unit with 12 beds, and so it's six double rooms.

20 If the six rooms -- if they're all full  
21 except for the sixth room and it has a young woman  
22 in it, you can't put a teenage boy in there, and  
23 you can't put an adult patient in there. So it's  
24 effectively full even though there's only 11 beds.  
25 And they have different buildings for different

1 services. They have another building called -- that's  
2 the Willow Building. They have a building called the  
3 Spruce Building which has 14 geropsychiatric beds.  
4 Well, you can't mix patients across those buildings.

5           And so they may say they have 10 percent  
6 -- they may say they have 10 percent availability, but  
7 if you look at the building-by-building analysis, it  
8 may not be that way. And you'll see that in those  
9 flow sheets I referenced earlier, those daily logs,  
10 because many times they will say we have one bed in  
11 Willow or one bed in Spruce, but we can only take a  
12 male or a female in that bed.

13           One of the things that our opponents  
14 certainly say we should do is look at the impact of  
15 our project on Woodridge. Well, Woodridge is full.  
16 You can't fit many more patients in there. And  
17 they're keeping Sullivan countians out and Hawkins  
18 countians out, and the reason that they gave for that  
19 was there's not a bed. Sometimes they gave other  
20 reasons, but the primary reason is there's no bed  
21 available.

22           We didn't know all this level of detail  
23 when the application was filed or even before the  
24 hearing, but that is the case today, the de novo case  
25 today. Woodridge is very full. We've proposed a

1 solution to the problem at least for Hawkins and  
2 Sullivan County and Virginia counties to the north,  
3 and one of the things that we take -- and I think you  
4 saw it in our memoranda on one of these motions, is we  
5 say there's a need up there in Northeast Tennessee for  
6 addiction care, for additional mental health services.

7           And Mr. Levine, the president of Mountain  
8 States, basically agrees with us. They have press  
9 releases on Wellmont and Mountain States' websites  
10 from back in April saying, you know, we're pursuing  
11 this COPA because there's this -- one of the top three  
12 -- there's three needs that he lists, top three needs,  
13 and the third one is the need for additional access to  
14 addiction care and behavioral health services.

15           And you will hear proof in this case  
16 of the state of the mental health care system up in  
17 Northeast Tennessee through Dr. Elliott, who, by the  
18 way, is on his way here. And as part of my -- I meant  
19 to say this earlier. He will get here hopefully  
20 around noon, and if Mr. Shaheen is on, I hope to --  
21 because Dr. Elliott is traveling -- to be able to  
22 interject him into the proceedings so he can be  
23 directly examined and cross-examined and be on his  
24 way, if that's all right. So we'll deal with that  
25 when I hear from my secretary, but I spoke with him

1 yesterday and he said that's what his plan was.

2           So the question then is need, economic  
3 feasibility, and contribution to orderly development.  
4 We have the burden; we feel like we've shown it, and  
5 we'll show it again in this hearing, the need is  
6 there. Because in our service area, the one that we  
7 identified -- Hawkins, Sullivan, and three Virginia  
8 counties -- there are only 12 beds and they're largely  
9 full or two-thirds full.

10           And so in that service area, there's no  
11 other place to go, Hawkins or Sullivan. You can't go  
12 to a psych hospital unless you go over to BRMC over in  
13 the -- Bristol Regional, over in the eastern part of  
14 Sullivan, and it's already two-thirds full.

15           And the tradition and rules of the Agency  
16 permit the applicant to name its service area, to  
17 designate a service area where most of its patients  
18 will come from. There is a recent CON decision that  
19 we'll present that a hospital in Rutherford County,  
20 TrustPoint, was recently -- just a few months ago  
21 was approved to have a significant psychiatric bed  
22 addition that will leave it with more beds than  
23 Vanderbilt, and it claimed a two-county service area,  
24 Rutherford and Bedford. And it was already claimed as  
25 a service area in Rolling Hills' application several

1 months before.

2 Well, they claimed a very broad area,  
3 including Rutherford and Bedford, but the Agency  
4 granted them their Certificate of Need, in part,  
5 because it sees this problem with the limitations  
6 on public inpatient psychiatric hospital beds and the  
7 closure, for example, at Lakeshore, the only one that  
8 has actually closed.

9 There have been similar reductions in  
10 psychiatric beds or resources focused that way across  
11 the state and across the country so that HSDA has  
12 said, very rightly, in these decisions -- it has  
13 approved a number of these, and I think that's  
14 recognition by them, as the health planning body for  
15 the state of Tennessee, or the one that executes the  
16 health planning decisions, that this is a crisis and  
17 it needs to be met.

18 And that crisis extends -- applies  
19 especially in Upper East Tennessee. You've got an  
20 84-bed hospital in Johnson City. That's the primary  
21 provider of inpatient psych services. You've got no  
22 other sizable inpatient psych hospital in the area  
23 anywhere. You've got 12 beds over in eastern Sullivan  
24 County that are 70 percent full -- or 65 percent full,  
25 and you've got hundreds of Sullivan countians and

1 Hawkins countians being turned away because there's no  
2 beds at Woodridge. So where else can they go? They  
3 can't go many places. And so that is a crisis  
4 situation, and we propose to assist in the resolving  
5 of it.

6 Will we be economically feasible?

7 Mr. Shaheen will testify about his company. He's been  
8 successful in developing a number of hospitals. And I  
9 think you will see, he will confirm in his testimony  
10 that he knows how to run a hospital company and  
11 Strategic knows how to be a successful company and it  
12 will be successful up in this area.

13 Will it contribute to the orderly  
14 development of health care? Well, certainly it will  
15 if it provides these unneeded services in this service  
16 area. It works -- it is proposing to work with ETSU's  
17 medical school. It works with other medical schools  
18 in the other areas that it has hospitals.

19 So all of those things -- and it will  
20 bring in, I think -- and Mr. Shaheen will address  
21 this. It will bring in additional health care  
22 resources, psychiatric/mental health/health care  
23 resources into the service area.

24 A lot has been made by our opponents  
25 about the need for outpatient care. Mr. Shaheen has

1 said and I think will provide testimony about, this  
2 hospital will provide outpatient care, outpatient care  
3 programs. His other hospitals do. He has a track  
4 record on that. And on the other hand, when we took  
5 proof from Mountain States' employees, they confirmed  
6 they'd actually closed down an outpatient program in  
7 Johnson City, or somewhere around Johnson City, that  
8 was providing outpatient psych care.

9           So, overall, there's a crisis. There's  
10 a crying need for additional addiction care and  
11 behavioral health care in Upper East Tennessee. We  
12 have picked out a logical service area. We have  
13 targeted the people there. It has the need. It meets  
14 the formula, the Guidelines For Growth which are  
15 advisory, but they are persuasive, I think, in this  
16 case.

17           And if a hospital is running at 90 to  
18 95 percent occupancy and claims some kind of negative  
19 impact on them from our business, I think they're  
20 erratically overstating the case, especially when they  
21 are a service of -- this is what their website says.  
22 Woodridge has a sign that says "Woodridge Hospital" --  
23 or "Woodridge, a service of Johnson City Medical  
24 Center."

25           Now, it says that because it is a

1 satellite of Johnson City Medical Center, Mountain  
2 States' flagship hospital, a great hospital. The  
3 Medicare regulations say that if you are a satellite  
4 of another hospital, you have to hold yourself out to  
5 the public as being part of that hospital. That's  
6 what that sign means; they're carrying out that  
7 Medicare obligation. They also have to share medical  
8 staffs. Well, they do that too. They also have to  
9 share revenue and expenses.

10           So if they're sharing revenue and  
11 expenses with Johnson City Medical Center, a highly  
12 profitable hospital, one that is probably the most  
13 profitable in the Mountain States' armamentarium of  
14 hospitals, then the impact of our project on them,  
15 regardless of all the claims that they make, will not  
16 be significant.

17           And also Mountain States is a single  
18 corporation. It's not a bunch of subsidiaries owned  
19 by a mother ship. This is a single corporation doing  
20 business as its various hospitals. Now, it does have  
21 some joint ventures, but generally those are, like,  
22 for rehab or other things.

23           But Woodridge is Mountain States.  
24 Johnson City Medical Center is Mountain States.  
25 And so Mountain States as an entity has massive

1 resources. I think it's about a billion dollars in  
2 assets, if I'm not mistaken, but our expert will deal  
3 with that.

4 But the point is, the claims that  
5 Mountain States is going to close Woodridge or  
6 significantly reduce services or take some other  
7 highly negative action if we're approved are not  
8 logical, given the fact that Mountain States itself is  
9 highly successful. It is highly leveraged, but it is  
10 highly successful, especially currently, I think the  
11 records will show, and Woodridge itself is part of  
12 Johnson City Medical Center, which is a very  
13 profitable hospital.

14 So the claims of impact may look  
15 significant if you don't understand the corporate  
16 structure of Mountain States. And we have tried to  
17 set forth in our arguments and our briefs and so  
18 forth, and we'll certainly set forth here, the impact  
19 of being a satellite facility, because they are a part  
20 of Johnson City Medical. They can't deny it.

21 They're estopped from denying it because  
22 if they did, they'd lose their -- it would cause them  
23 a lot problems with Medicare because they'd be  
24 disclaiming the fact that they're a satellite of  
25 Johnson City Medical Center. The regs for the state,

1 you have to say to the public you are, and they do on  
2 their website.

3           So in light of all these things, we  
4 think we'll meet our burden of proof, have met our  
5 burden of proof. We think the need is clearly there.  
6 The economic capabilities -- economic feasibility  
7 of the project is clearly there, given the strength  
8 and experience of Mr. Shaheen's company, and the  
9 contribution to orderly development is there in the  
10 sense that we will work with the medical schools, we  
11 will bring in additional professionals, we will do all  
12 these things to improve the behavioral health system  
13 of Northeast Tennessee, particularly in Hawkins and  
14 Sullivan counties.

15           And by the way, Hawkins County is the  
16 ninth largest county in Tennessee. These are not  
17 small, rural counties. Hawkins County has more people  
18 in it than Washington County where Johnson City is.  
19 So this is a significant population that we propose to  
20 assist in meeting their needs for behavioral health  
21 care both on the inpatient and outpatient front.

22           So from that standpoint, we believe that  
23 we have shown and will show in this proceeding that  
24 the project is needed, it's economically feasible, and  
25 will contribute to the orderly development of health

1 care.

2 THE COURT: Mr. Jackson?

3 MR. JACKSON: Your Honor, I have a couple  
4 of boards I wanted to get. Could I ask for a quick  
5 break to go down the hall as well?

6 THE COURT: Certainly. We'll take a  
7 short break.

8 (Recess observed.)

9 THE COURT: Mr. Jackson?

10 MR. JACKSON: Thank you, Your Honor.  
11 May it please the Court, I'm Brian Jackson, again,  
12 and along with Travis Swearingen, it's my privilege  
13 to speak for Mountain States Health Alliance in this  
14 case. I may refer to Mountain States occasionally  
15 either as simply Mountain States or as MSHA, its  
16 acronym, if that's all right with Your Honor.

17 Mountain States is a nonprofit health  
18 care system with its principal offices in Johnson  
19 City, which, as Your Honor knows, is located in  
20 Washington County. Mountain States owns and operates  
21 several hospitals in Upper East Tennessee, including  
22 the Johnson City Medical Center, which is a 501-bed  
23 tertiary care center, and including, also, Woodridge  
24 Psychiatric Hospital, which is an 84-bed facility  
25 located just across the street from Johnson City

1 Medical Center.

2 Woodridge is the leading provider of  
3 psychiatric services in the Tri-Cities area, although  
4 it's not the only provider. And there are actually a  
5 few more resources that Mr. West mentioned in his  
6 statement which I'll mention to Your Honor as we go  
7 forward. But Woodridge is the leading provider of  
8 services in this general Tri-Cities region of the  
9 state.

10 And, of course, in this case, the  
11 applicant, SBH, wants to build a new psychiatric  
12 hospital in Kingsport about 24 miles from the  
13 Woodridge Psychiatric Hospital in Johnson City, and  
14 the application was denied by the Agency.

15 And I know Your Honor has heard that  
16 it was a tie vote, and that's true, but a tie vote is  
17 a denial under the rules that we operate under with  
18 the Agency, and therefore this case arrives at Your  
19 Honor's doorstep as a denied CON, which means, of  
20 course, that SBH does have the burden of proof. And  
21 SBH has the burden of proof of showing, first of all,  
22 that there's a need for this project from a health  
23 planning perspective.

24 Secondly, they have the burden of proving  
25 that this project is economically feasible and taking

1 into account alternatives, as well, in making that  
2 analysis, as I'll discuss.

3 They also have the burden of proving that  
4 that project, if approved, would contribute to the  
5 orderly development of adequate and effective health  
6 care facilities in this part of our state.

7 And it's important to remember that they  
8 have to establish not just one of these criteria, not  
9 just two, but all of them.

10 So what will the proof show about the  
11 first criterion, which is need? First, we'll, of  
12 course, look to the State Health Plan. And it is  
13 mandated by the statutes that the State Health Plan be  
14 considered in evaluating any CON project.

15 And I have to respectfully disagree with  
16 some of the suggestions in the brief SBH filed before  
17 trial to the effect that the Agency rules can somehow  
18 limit the statute's requirement. I mean, the statute  
19 is plain. The State Health Plan must be considered as  
20 the first point of analysis for any project.

21 And the State Health Plan sets out --  
22 first of all, in addition to other criteria, it sets  
23 out a mathematical need formula that is one part of  
24 the need analysis. And, of course, any consideration  
25 of bed formula, bed-need formula of that sort has to

1 be considered in relation to a service area.

2 Service area. You know, obviously you  
3 have to know what your service area is before you can  
4 analyze how many beds there are and then apply the  
5 mathematical formula to the population to figure out  
6 how many beds may be needed. And a central issue  
7 in this case, as Your Honor has already heard, will be  
8 the service area that is appropriate and reasonable  
9 for this project in Kingsport, a psychiatric hospital.

10 And what the proof is going to show is  
11 that the petitioner, SBH, has selected -- basically  
12 they've selected two counties in Tennessee, Sullivan  
13 and Hawkins County, and we'll look at a map here in a  
14 second that will help orient us all, and three  
15 sparsely populated counties in Virginia, and they've  
16 declared that that is their service area for this  
17 inpatient psychiatric hospital in Kingsport.

18 We're going to see in our proof that  
19 this selection of a service area was based not on any  
20 legitimate health planning rationale but basically for  
21 purposes of gaining the CON system; that is to say for  
22 purposes of overstating the need and understating  
23 existing resources.

24 And we heard it even in the opening  
25 statement today where Mr. West said several times

1 there's nothing available for people in Sullivan  
2 County other than the 12 beds at Wellmont Bristol  
3 Regional Medical Center in Bristol. He said, oh,  
4 there's 12 beds in Bristol, but that's it.

5 Well, that's because the way they've  
6 defined their service area excluded 28 additional beds  
7 that are located in Bristol, Virginia, just over the  
8 state line and about three miles from Wellmont Bristol  
9 Regional Medical Center.

10 So, in other words, there you see a good  
11 example of how this gerrymandering of the service area  
12 can create a false impression as to what kind of  
13 resources you have in an area. In fact, those 28 beds  
14 in Bristol, Virginia, are just as accessible to those  
15 who live in Sullivan County as the 12 beds that he  
16 mentioned several times in Bristol, Tennessee, three  
17 miles away.

18 But what they have done in creating this  
19 service area, they've done it to -- for the express  
20 purpose of excluding Washington County and thereby  
21 excluding 84 -- its 84 beds, and then it also  
22 excludes, as I mentioned, these beds in Virginia.

23 And the effect of all this is to  
24 overstate the need and to minimize existing resources  
25 and, of course, avoid addressing, really, the impact

1 that this project will have on those existing  
2 providers that have been gerrymandered out of the  
3 service area.

4 So one of the key questions for Your  
5 Honor in this case will be: Is that service area  
6 reasonable? Because under the State Health Plan, as  
7 we've set out in our brief, a service area can't be  
8 just dreamed up. It has to be reasonable, and it has  
9 to reflect where the patients are actually going to be  
10 coming from for this new facility.

11 And as we proceed, I would suggest that  
12 the Court should ask: Is it reasonable for this  
13 applicant to exclude Washington County with Johnson  
14 City in it, given the longstanding commercial and  
15 cultural and other ties between these two cities  
16 which, of course, are two of the three cities that we  
17 commonly call the Tri-Cities.

18 Is it reasonable to exclude Washington  
19 County in light of the fact that Woodridge is  
20 currently the leading provider of psychiatric services  
21 for people living in Sullivan County and for people  
22 living all over their claimed service area?

23 Is it reasonable to exclude Washington  
24 County right next door, just 24 miles away, to the  
25 hospital. The county line is actually quite a bit

1 closer than that. Is it reasonable to exclude  
2 Washington County when you have direct interstate  
3 access but to include Lee County which is up in  
4 Virginia, in rural Virginia? And the proof is going  
5 to show that basically no patients from Lee County --  
6 or a tiny handful ever seek psychiatric care down in  
7 the Tri-Cities.

8 This is a map, Your Honor, showing the  
9 proposed service area that the applicant has proposed,  
10 and you can see the proposed site. This is Kingsport  
11 here (indicating). Obviously, Bristol is over on the  
12 Virginia line. And I'm going to hopefully get a map  
13 that has all the cities. I should have prepared one.

14 But, you see, this Lee County up here  
15 is part of the service area. Washington County, as  
16 you'll see from this map, which represents, we would  
17 submit and what the proof will show, is a reasonable  
18 service area for the proposed new hospital --  
19 Washington County is right here (indicating), due  
20 south, connected by good interstate highway access to  
21 Kingsport.

22 So we believe the proof is going to  
23 show that it makes no sense from a health planning  
24 perspective to include these counties up here in  
25 Virginia who are -- first of all, very few people live

1 in them.

2           Secondly, the access is much different.  
3 Obviously, this is a mountainous area, as Your Honor  
4 probably knows. The access from here, from Lee County  
5 to Kingsport is much different from Kingsport to  
6 Johnson City which is connected by, basically, a flat  
7 interstate highway that's easy to travel.

8           Is it reasonable for the applicant to  
9 ignore the historical fact that when there was a  
10 psychiatric hospital in Kingsport just a few years  
11 ago -- Indian Path Psychiatric Pavilion existed and  
12 was operational there in Kingsport literally just down  
13 the street from where SBH wants to build its new  
14 hospital.

15           During that period that that hospital  
16 was operational, far more patients came to it from  
17 Washington County than from most of these other  
18 counties that the applicant is claiming are its  
19 primary service area, certainly far more than from  
20 Lee County, far more than from these Virginia  
21 counties, which we submit are not going to be  
22 generating the patients who are going to be seen at  
23 this new hospital.

24           On all these points, we're going to offer  
25 the testimony of Dr. Deborah Kolb Collier, who is one

1 of the leading health planning experts. She has  
2 extensive experience with CON matters in Tennessee and  
3 in other states. She has performed an analysis, and  
4 it's not based on generalities; it's based on data.

5 And what she's come up with is this, Map  
6 Number 8 which I have before Your Honor. And she will  
7 explain why this is a more reasonable service area for  
8 the Kingsport hospital than the truncated service area  
9 that's been proposed by the applicant.

10 She will also explain that if we do it  
11 another way and look at the history -- this is the  
12 historical service area of Indian Path Psychiatric  
13 Pavilion, the hospital that closed in 2009 in  
14 Kingsport, treating psychiatric patients just like  
15 this applicant.

16 And you will see that the patients to  
17 that facility in Kingsport, the Number 2 origin for  
18 those patients was Washington County with 12 percent  
19 of the patients. And you will see that the counties  
20 that are claimed -- Scott, Lee, and Wise -- Lee didn't  
21 even appear on the map because it contributed so few  
22 patients to the Indian Path Psychiatric Hospital, and  
23 these other counties contributed very, very few  
24 patients.

25 So I think you'll agree, after you hear

1 from Dr. Collier, that either of these service areas,  
2 either the one she's proposed based on her analysis,  
3 which she'll explain to you, or if you just look at  
4 history, the way -- the actual patients, where they  
5 came from when there last was a hospital in Kingsport,  
6 a psychiatric hospital -- I think you'll agree that  
7 either of those service areas is far more reasonable  
8 than the one that is submitted by the applicant.

9           And the reason this is so important was  
10 that if you do adopt a reasonable service area for  
11 this application and then you apply the bed-need  
12 formula under the State Health Plan, there's no need  
13 for a 72-bed hospital in Kingsport, just the numbers  
14 don't work out. There is some modest need that is  
15 shown in the neighborhood of 30 beds, but there's  
16 nowhere near a 72-bed need that is required for this  
17 application.

18           In evaluating this issue of need, it  
19 is also important to look at and understand what  
20 resources are available in the area. And we will be  
21 bringing to you Ms. Marlene Bailey, who's the director  
22 of behavioral health services at Woodridge, and she's  
23 been there for a very long time. Thirty years she's  
24 been at that facility, even before Mountain States  
25 owned it. So she carries with her a great

1 institutional knowledge.

2 She'll explain to you that Woodridge is  
3 a full-service psychiatric hospital that has 58 adult  
4 beds, 14 geropsych beds, and 12 child and adolescent  
5 beds. And she'll explain the steps that Woodridge has  
6 taken in recent years to enhance its patient access to  
7 psychiatric services. And it is true that the census  
8 at Woodridge has been trending up as a result of these  
9 efforts; although, I would point out -- Mr. West  
10 mentioned all these percentages.

11 The proof's going to show that every  
12 hospital run by SBH runs at 80 to 90 percent capacity.  
13 So it's not unusual for psychiatric hospitals to run  
14 at 80 to 90 percent capacity. And that fact standing  
15 alone doesn't mean that you have to build a new  
16 psychiatric hospital.

17 We're going to offer testimony explaining  
18 why the census is up. We're also going to offer  
19 testimony which explains what we're doing at Woodridge  
20 to improve utilization of the existing resources,  
21 including a crisis stabilization unit for adolescents  
22 which is being developed and should be operational by  
23 the end of this year which will help to alleviate the  
24 pressure on the inpatient beds, the demand for  
25 inpatient beds. So you'll hear testimony about that.

1           But at the end of the day, with respect  
2 to the need element, we think it will be an easy  
3 conclusion for you to reach that the service area in  
4 this case is not reasonable, the claimed service area  
5 of the applicant, it's too small. It omits Washington  
6 County, which makes no sense based either on  
7 population, on historic patient flow patterns.

8           And you also find that patients in this  
9 area have good access to patient quality care. In the  
10 service area, as Dr. Collier calculates it, there are  
11 a total of 172 beds available to people living in that  
12 area. So this idea that there's, you know, no beds  
13 available to people in Upper East Tennessee is simply  
14 not accurate based on the existing resources. And  
15 you can see them there on the map. They're spread  
16 throughout the region. The little boxes show where  
17 there are psychiatric beds in this area.

18           Now, need, of course, is not the only  
19 criterion. There's economic feasibility. And no one  
20 disputes that SBH has the financial wherewithal to  
21 build the facility. They've created a very profitable  
22 business model in other states. They have a couple of  
23 different templates, and they build these hospitals.  
24 They focus on better insured patients, they avoid  
25 providing much charity care, and that's been very

1 profitable for them. And the proof will show, in this  
2 case, they project a 50 percent return on their equity  
3 investment here.

4 But that's not the only question to be  
5 asked in the economic analysis. People always think  
6 that that's all the economic prong requires is that we  
7 look at can someone build it. But there's also, in  
8 the rules and regulations, the concept of whether  
9 there are less costly alternatives that have been  
10 considered to this project than what is being  
11 proposed.

12 The proof is going to show that SBH  
13 never considered any size other than a 72-bed hospital  
14 because -- and that wasn't because there was any  
15 analysis done saying, gosh, there's 72 beds needed in  
16 this community. It was because they have a couple of  
17 prepackaged plans where that's one of their options;  
18 72 beds is one of their standard templates.

19 The proof will show that there was  
20 absolutely no discussion of sizing this project in  
21 any way that might be more appropriate for this  
22 area. The proof will also show there was no real  
23 consideration given to any partnership with any  
24 existing provider in the area. And the proof will  
25 show there are more cost-effective and desirable ways

1 of taking care of the mental health needs of people  
2 who are living in this area.

3 And you're going to hear about -- I've  
4 mentioned already this CSU, a crisis stabilization  
5 unit, and it's a project that the folks at Mountain  
6 States are very excited about that they're doing with  
7 Frontier, which is a -- you'll hear from a Frontier  
8 representative.

9 Dr. Jessee from Frontier is going  
10 to come and explain what they do and how they're  
11 partnering with Mountain States to create this  
12 crisis stabilization unit for adolescents. And it's  
13 exciting because it's an alternative to inpatient  
14 hospitalization for adolescents who are having mental  
15 health problems.

16 We're also going to offer you testimony  
17 largely through Dr. Trivedi, who's the head of the  
18 psychiatric hospital at Vanderbilt Medical Center.  
19 He's going to come and testify, and he's going to  
20 explain that in the mental health area, inpatient  
21 hospitalization is really the last resort. It's not  
22 desirable, for an obvious reason. It restricts a  
23 patient's liberty, it's unpleasant for patients, and  
24 it's expensive.

25 And so what we're doing in the mental

1 health area, what people at Mountain States and  
2 Frontier are trying to do is create alternatives to  
3 hospitalization, so to the extent that there are  
4 unaddressed needs in the Upper East Tennessee  
5 community, they can address those through the  
6 innovative programs such as the CSU and not simply  
7 coming in and building more inpatient beds to fill  
8 with patients.

9           The final criterion, of course, is the  
10 orderly development of health care question. And what  
11 the proof is going to show, if you look at the overall  
12 picture -- this is the element of the case where you  
13 sort of step back and look at the big picture. If  
14 you look at the big picture, in Upper East Tennessee,  
15 what you see is this is an area with good access to  
16 inpatient psychiatric care as reflected by a couple of  
17 indicators.

18           For one, if you look at use rates, use  
19 rates are a way we have of measuring whether people  
20 are getting good access to care, and that's the extent  
21 to which a population is using health care services,  
22 in this case, inpatient psychiatric services.

23           If you study the use rates in Upper East  
24 Tennessee and in Sullivan and Washington counties, in  
25 particular, you'll see that they're higher than the

1 state average, meaning people in these communities are  
2 using inpatient psychiatric services more than the  
3 average in Tennessee.

4 So this image that has been suggested to  
5 you by the opening statement of Mr. West that this is  
6 an area in crisis without access is simply not borne  
7 out by the fact that the use rates in this area are  
8 higher than the state average.

9 You'll also see that there's good access  
10 in this area based on geographic access, and that's  
11 drive times. You'll hear there's generally accepted  
12 standards. Generally, even Mr. Sullivan, the  
13 applicant's expert, admits that an hour drive time  
14 is a reasonable drive time for accessing inpatient  
15 psychiatric services.

16 Those services are more centralized.  
17 They're not the same as a dialysis clinic or an MRI  
18 that you want to have, you know, one of those in  
19 every -- even the smaller communities. Inpatient  
20 psychiatric hospitals are more centralized than that,  
21 as is evidenced by the fact that we have -- I think  
22 there's fewer than 15 of them, freestanding ones, in  
23 the state, and there's 95 counties in our state.

24 So, clearly, these are not services that  
25 we expect to have on every street corner. One-hour

1 access is considered reasonable access even by the  
2 applicant's own expert. And if you study this area,  
3 you will see that the people who live in the area,  
4 the Tennessee residents, in particular, who live in  
5 this area, have good access to existing psychiatric  
6 facilities.

7 Another thing you may look at to see  
8 if people aren't getting the care that they need in  
9 an area is out-migration. Are people having to go  
10 elsewhere to get treatment? And the number we're  
11 going to show you, the actual numbers, they're not  
12 disputed and they're not that substantial. The people  
13 who are leaving the area for care do not amount to a  
14 number that will be anywhere near sufficient to fill  
15 the beds of this new hospital even if 100 percent of  
16 them started going to the new hospital instead of  
17 going down to Knoxville, which is where most of them  
18 are going. It's just about an hour and a half's drive  
19 down to Knoxville.

20 You will hear that the closure of the  
21 public health beds has generated some pressures in the  
22 system, but the real pressure has been economically in  
23 that there are a large number of patients previously  
24 seen at the state hospital who are now being seen at  
25 Woodridge and at Peninsula in Knoxville through

1 agreements that these hospitals reached with the  
2 state to care for these patients.

3           So what that means is that all these  
4 patients who previously were admitted to the state  
5 hospital are being sent either to Woodridge or down to  
6 Knoxville to Peninsula pursuant to these contracts.  
7 And you'll hear testimony that while these contracts  
8 with the state do provide some reimbursement for the  
9 patients, all of whom are uninsured and largely  
10 destitute -- while the state does provide some  
11 reimbursement, it does not cover the full cost of  
12 treating these patients and that Woodridge and other  
13 -- Peninsula as well, presumably, are providing these  
14 patients care at a loss because it's part of their  
15 mission as nonprofits.

16           But that fact, while it has created some  
17 pressures on bed availability from time to time, that  
18 fact shouldn't be used -- the pressures arising from  
19 that shouldn't be used as a weapon against Mountain  
20 States, if you will, in this proceeding; that is to  
21 say Mountain States has taken on a very significant  
22 responsibility to the state for the care of these  
23 patients and is undercompensated for it.

24           And to allow a for-profit provider to  
25 come into the area when there's no real need and to

1 re-allocate significant numbers of insured patients  
2 from Mountain States to the new provider would be  
3 detrimental to the orderly development of health care.

4 And what we're going to see is that the  
5 applicant projects that they will see almost 2,000  
6 cases in their new hospital by Year 2, and that's  
7 assuming a 62 percent occupancy, I might add. And  
8 we'll also show you that all of their hospitals, once  
9 they're up and running, run at 80 to 90 percent  
10 occupancy. So the 2,000 cases is a very low number.  
11 Once they're up and running, it's clearly going to be  
12 well north of 2,000 cases that will be seen at this  
13 hospital.

14 Looking at the current patterns of  
15 patient flow between these counties, it's obvious  
16 that a substantial -- probably most of those patients  
17 would be patients who otherwise would have been seen  
18 at Woodridge in Johnson City. And Dr. Collier says  
19 there will be about 1,000 cases lost. Assuming,  
20 again, the 62 percent occupancy number, 1,000 of  
21 those cases, approximately, will be coming from  
22 Woodridge, essentially people who would have been  
23 seen at Woodridge previously, and these patients are  
24 disproportionately insured. That is to say the new  
25 provider won't be taking these state patients that

1 would formerly have been seen at the state facility;  
2 they'll be taking the people with insurance, with  
3 Medicare, with other private insurance.

4           The applicant really has no answer to  
5 this impact analysis other than they want to nitpick  
6 about it. They want to say -- they've done no impact  
7 analysis of their own. They have Mr. Sullivan, their  
8 expert. He's done it many times before, but he wasn't  
9 asked to do it in this case. So they've done no  
10 analysis themselves to identify how -- where these  
11 2,000 cases are going to come from and how that's  
12 going to upset or change the existing patient patterns  
13 in the area.

14           They want to talk about this fact that  
15 Woodridge is a satellite of Johnson City Medical  
16 Center, which it is, as though that means that any  
17 impact is just meaningless or trivial. But simply  
18 because Woodridge is affiliated and attached to a  
19 successful medical center does not change the fact  
20 that 1,000 cases would represent more than 25 percent  
21 -- or approximately 25 percent of the volume of  
22 patients at Woodridge in a given year. That's going  
23 to be, obviously, a materially detrimental impact.

24           And simply the fact that there are other  
25 aspects of the Mountain States system, other elements

1 that may make money to offset that impact, doesn't  
2 change the fact that the impact is there. And I would  
3 point out also that Mountain States, while it is  
4 operationally healthy, is, as Mr. West even  
5 acknowledged, highly leveraged. He mentioned a  
6 billion dollars in assets, but I don't think he  
7 mentioned the debts which I believe are about  
8 \$1.3 million.

9           So the idea that the system is simply  
10 awash in cash and can deal with any impact is simply  
11 not going to be borne out by the proof. And we're  
12 going to offer you Mr. Levine who's going to come and  
13 tell -- who's the CEO -- he's going to come and tell  
14 you about what this impact may mean and will explain  
15 that this is not a trivial matter, to say the least,  
16 to lose these kind of patient volumes.

17           And Dr. Collier's estimate is it's going  
18 to be between one and a half and \$2 million annually  
19 to the bottom line of the Woodridge Psychiatric  
20 Hospital if this project was approved.

21           So, Your Honor, at the end of the day,  
22 we're confident that the proof is going to show  
23 that the Agency was correct when it denied this  
24 application; that there's simply no demonstrated need.  
25 The service area has been gerrymandered to create a

1 need where none exists, and to approve it would have a  
2 significant detrimental impact on a provider in Upper  
3 East Tennessee that is providing important health care  
4 services to our state.

5 Thank you.

6 THE COURT: Thank you, Mr. Jackson.

7 Mr. West, you can call your first  
8 witness.

9 MR. JACKSON: Petitioner calls James  
10 Shaheen as the first witness.

11 JAMES SHAHEEN

12 was called as a witness, and after having been first  
13 duly sworn, was examined and testified as follows:

14 DIRECT EXAMINATION

15 BY MR. WEST:

16 Q. All right. Mr. Shaheen, we stated your name  
17 for the record and you've been sworn in. Could you  
18 describe for the Court your position and where you  
19 live?

20 A. Sure.

21 THE COURT: Before you do that, will you  
22 spell your last name, please.

23 THE WITNESS: S-H-A-H-E-E-N.

24 THE COURT: Thank you.

25 THE WITNESS: I'm the founder and

1 president of Strategic Behavioral Health. I started  
2 this company just under ten years ago -- it will be  
3 ten years this January -- with the sole purpose of  
4 building freestanding psychiatric hospitals and  
5 acquiring some.

6 BY MR. WEST:

7 Q. When you say Strategic Behavioral Health,  
8 that's actually Strategic Behavioral Health  
9 Incorporated; is that right?

10 A. It's Strategic Behavioral Health, LLC, is the  
11 parent organization.

12 Q. And the applicant in this case is called  
13 SBH-Kingsport, LLC. What is the relationship of that  
14 entity to your company?

15 A. It is a single-member-owned LLC, wholly owned  
16 by Strategic Behavioral Health, LLC, the parent  
17 company.

18 Q. Would you describe for the Court the history  
19 of how you founded SBH, LLC, and where it's based and  
20 that type of stuff?

21 A. Sure. So 11 years ago or so, I was running a  
22 hospital in Memphis, Tennessee, and recognized that  
23 there was a need for -- nationally, a need for  
24 additional psychiatric hospitals to not only be  
25 created but built, simply because new facilities,

1 physical plants, had not been built in 20 or 30 years  
2 around the country and all of those buildings were  
3 getting older and folks were renovating med/surg  
4 hospitals or nursing homes or things likes that,  
5 things that were not designed specifically for this  
6 patient population in mind.

7 Q. Let me interject right there. What kind of  
8 hospital were you working at before --

9 A. It was a child and adolescent facility here in  
10 Tennessee.

11 Q. A psychiatric facility?

12 A. Yes.

13 Q. Okay. Go ahead and tell the rest of the  
14 story, then.

15 A. And so the goal was to take the first couple  
16 of years and study where there were needs around the  
17 country. And so I actually flew around to different  
18 parts of the country and was looking at different  
19 areas where there was needs.

20 The first place I happened to run into  
21 was Wilmington, North Carolina, and that's where I  
22 actually built my first facility, a 72-bed child and  
23 adolescent facility in Wilmington, North Carolina, and  
24 in 2008 we took our first patient in that facility.

25 In 2009, I built a 21-bed geriatric facility

1 in Colorado Springs, Colorado, with the intent of  
2 building a 92-bed facility there, which I did,  
3 subsequently, three years later, but wanted to get  
4 into the market quicker rather than wait on building  
5 the building and a larger building, so we opened up a  
6 21-bed geriatric psychiatric facility there.

7 I then acquired a couple of facilities in  
8 Las Vegas, Nevada, two 30-year-old facilities with a  
9 total of 80 beds in one and 21 beds in another.

10 I then built a 92-bed facility in Raleigh,  
11 North Carolina, that operates today, again, for  
12 children and adolescents because that was the need  
13 that was identified in those given markets.

14 And then I built a 60-bed facility in  
15 Charlotte, North Carolina, again, for child and  
16 adolescents.

17 I then built a 72-bed psychiatric hospital in  
18 College Station, Texas, and that facility opened April  
19 of last year, so it's been open just over a year now.

20 I then acquired a 119-bed facility in New  
21 Mexico, and it does both the residential and acute  
22 for all populations.

23 And then I built the 92-bed facility in  
24 Colorado Springs and I moved the 21 beds into the  
25 larger facility because there was such a need in the

1 marketplace for that.

2 Q. When you speak of these activities you refer  
3 to, you say that "I" built those. What do you mean by  
4 that?

5 A. Well, so I'm in -- my background is -- I'm  
6 an old recreational therapist, a mental health tech  
7 of -- it will be 27 years next month. I literally,  
8 career-wise, grew up in these facilities and got my  
9 first hospital CEO job when I was 30 years old and  
10 just understand the business, and so I personally  
11 designed the buildings.

12 I personally went to each of these facilities  
13 and hired the CEOs and the leadership teams of those  
14 facilities and oversaw their coming out of the ground  
15 and taking new patients.

16 I oversaw the entire construction process. I  
17 hired a construction company. I hired the architects.  
18 So when I say "I," I physically did all that much, to  
19 my wife's chagrin. I traveled a good bit, obviously.

20 Q. Do you plan that same range of activities at  
21 Kingsport if the CON gets granted?

22 A. We do. We do. We're a larger company  
23 now, so I've taught -- over the years I've taught my  
24 leadership team in the Memphis office to do a lot of  
25 that work now, but I continue to oversee it on a

1 day-to-day basis.

2 Q. With these hospitals that you have built --  
3 or SBH -- I'll use SBH, LLC -- I'll use the expression  
4 SBH has built, what is the corporate relationship  
5 between SBH, LLC, and the individual hospitals?

6 A. The individual hospitals are solely owned by  
7 the LLC, but each hospital is a stand-alone facility  
8 that has a CEO and a leadership team that manages and  
9 operates that facility on its own, 100 percent. So  
10 the corporate structure -- I have about 30 staff in  
11 the corporate office. Their sole role is to support  
12 those facilities and provide oversight and support.

13 But inside the hospitals, they are  
14 self-sufficient. They draw up their own bills. They  
15 collect their own cash. They do everything inside  
16 of those hospitals. There isn't a service at the  
17 corporate office that they provide to the facility and  
18 allocate costs or anything like that. They're  
19 stand-alone facilities.

20 Q. Does Strategic Behavioral Health, LLC, charge  
21 a management fee back to these individual  
22 corporations?

23 A. Not a dime. We do not charge a dime of  
24 overhead nor management to the facilities. If there  
25 is an expense that the facility has that the parent

1 office -- for example, we have national contracts,  
2 and so when we buy our staples, we might buy -- five  
3 different hospitals might buy the same equipment. The  
4 exact amount of that equipment on those invoices is  
5 allocated to that facility of the furniture that they  
6 got, so there isn't an overhead allocation. So  
7 whatever expenses that that facility incurs is the  
8 expenses that go on that facility.

9 Q. If you don't charge a management fee at the  
10 corporate level, how does Strategic Behavioral Health,  
11 LLC, have any money?

12 A. Because of the profits of all the companies  
13 together, because they're a single LLC and they roll  
14 up, and so the corporate overhead is all after total  
15 profits, and that's been the company's total  
16 profitability.

17 Q. And Strategic Behavioral Health, LLC, has it  
18 been profitable recently?

19 A. It has. It has. We've grown pretty  
20 significantly, both through acquisition and through  
21 new projects that we've built and brought out of the  
22 ground. As an example, when we filed this particular  
23 Certificate of Need, I think the latest audited  
24 financials had us at 50 million in revenue.

25 I think we've submitted in our -- the latest

1 audited financials, which would be 2014, it was 102  
2 million in revenue. So it's literally doubled since  
3 we have filed in terms of revenue, profitability as  
4 well. So we've been very successful.

5 Q. You have heard commentary here today and I  
6 think you've probably seen documents in this matter  
7 that talk about the level of charity care, for  
8 example, the SBH facilities in North Carolina. Can  
9 you address, especially in the North Carolina  
10 context -- address these issues?

11 A. I can. I've seen documents where we  
12 report our North Carolina payor mix within our state  
13 licensing. The interesting thing about North Carolina  
14 is they're strictly children and adolescents. I don't  
15 do any adult or geriatric work in North Carolina  
16 today.

17 What that means, from a practical standpoint,  
18 is the majority of those children are covered through  
19 a North Carolina Medicaid program or covered  
20 through --

21 MR. WEST: Your Honor, if I may interject  
22 just a minute -- I've got my back to the door, and I'm  
23 expecting a witness to show up. And I'm not sure --

24 You're not Dr. Elliott, are you?

25 UNIDENTIFIED SPEAKER: (Moves head from

1 side to side.)

2 MR. WEST: Okay. I don't have anybody  
3 back there looking. I'm sorry I interrupted.

4 MR. SWEARINGEN: Bill, I did see somebody  
5 poke their head in, so I don't know who...

6 MR. WEST: Could we take like a  
7 three-minute break, Your Honor, and let me see if  
8 they're here?

9 THE COURT: Yes.

10 MR. SWEARINGEN: He was in a suit, but I  
11 don't know if he was lost or what.

12 (Recess was observed.)

13 BY MR. WEST:

14 Q. I'm sorry I interrupted you, Mr. Shaheen. You  
15 were speaking of the North Carolina situation.

16 A. Yes.

17 Q. Could you proceed?

18 A. So the North Carolina situation, because it's  
19 strictly child and adolescent, those children in North  
20 Carolina are covered by either North Carolina Medicaid  
21 or commercial insurance.

22 In North Carolina, specifically, and in many  
23 states around the country, there is a provision in the  
24 law that requires -- not requires, that allows parents  
25 to get their child on Medicaid regardless of their

1 income.

2 So we have lots of circumstances where two  
3 physician parents might stand in front of a judge and  
4 say, "I'd like to get my child access to care," and  
5 the judge will grant them Medicaid. So that's why you  
6 don't have indigent children in North Carolina.

7 And if there are any children that the parents  
8 don't do that proceeding, in addition to that, the  
9 Medicaid provider -- they're called MCOs -- they  
10 actually have what are called three-way contracts to  
11 provide services for those children.

12 So in our hospitals in North Carolina, all  
13 of those kids come to us from a variety of referral  
14 sources. None of those children that come to us are  
15 indigent. If they are, we continue to treat them,  
16 admit them, but you'll see in our numbers, it's a very  
17 low number because of the way the system is designed  
18 in North Carolina, not because of our unwillingness to  
19 treat them.

20 Q. What percentage of your child and adolescent  
21 patients in your North Carolina facilities are  
22 Medicaid?

23 A. Gosh, I think today, off the top of my head,  
24 that probably runs 85 percent or so.

25 Q. And if a child truly is indigent in North

1 Carolina, do they also get Medicaid coverage?

2 A. Yes. They're typically eligible. It's  
3 called a lot of different terms, but "family of one"  
4 sometimes is the terminology used. The judge has the  
5 authority to grant them.

6 In addition, the state custody children  
7 automatically get Medicaid assigned to them when  
8 they go into state's custody and removed from their  
9 parents' custody.

10 So, again, that's -- those are the patients  
11 that we're treating, and so those are the patients  
12 that show up at our doorstep as well.

13 Q. I think you had mentioned this a moment ago in  
14 passing, but I wanted to ask you a few questions about  
15 it. How long have you personally been involved in the  
16 psychiatric hospital business or operations?

17 A. Twenty-seven years next month. And over  
18 the years I've worked for a variety of for-profit  
19 companies, both medical/surgical hospital companies  
20 as well as psychiatric hospital companies. And  
21 psychiatric and substance abuse care has been all I've  
22 done for that 27 years in treating this population.

23 Q. And what corporation -- or what hospital did  
24 you work at before you started Strategic Behavioral  
25 Health, LLC?

1 A. A company called Keystone Education & Youth  
2 based out of here, Nashville, Tennessee. The facility  
3 that I ran was Compass Intervention Center in Memphis,  
4 Tennessee. It was 108 beds doing children and  
5 adolescents.

6 Q. Was that an inpatient psych hospital?

7 A. It was a psychiatric -- they're called PRTFs,  
8 psychiatric residential treatment facility, that  
9 particular one was.

10 Prior to that, I ran a 113-bed psychiatric  
11 hospital in Savannah, Georgia, doing children,  
12 adolescents, adults and geriatric.

13 Prior to that, I ran a 102-bed psychiatric  
14 hospital on St. Simons Island, Georgia, doing  
15 children, adolescents, adults and geriatric.

16 And prior to that, I was in a psychiatric  
17 hospital, 72-bed psychiatric hospital in Bowling  
18 Green, Kentucky, where we did children, adolescents,  
19 adults and seniors as well there. I can sort of go  
20 all the way back 27 years, but that --

21 Q. That's plenty far.

22 A. Sure.

23 Q. What role, if any, did you play in the  
24 decision by SBH to file the Certificate of Need  
25 application we're here about today?

1 A. I'm the ultimate decision-maker. I have the  
2 right and authority to file a Certificate of Need  
3 where we have seen where there is a significant need.  
4 And so I have a development team. Specifically, in  
5 this case, Mike Garone, who I'm sure we'll hear from  
6 later, was charged with going to the community and  
7 evaluating the community. I went with him a couple of  
8 times as well, and we discussed those and determined  
9 that there was a need, based on being on the ground  
10 there, and was able to make the decision that we  
11 should file a Certificate of Need there.

12 Q. Did you go there before the CON was filed?

13 A. Yes, I think I did.

14 Q. And why was the particular layout that you  
15 have -- that the CON application describes for this  
16 hospital in Kingsport, why was that layout chosen?

17 A. When we got to the community and really  
18 began talking to all of the stakeholders -- and I  
19 think you'll see later in our stuff the volume of  
20 stakeholders that we met with to find out what the  
21 true needs were -- we understood that there was a  
22 large children and adolescent need, we understood that  
23 there was a large geriatric need, we understood that  
24 there was a large chemical dependency need, and there  
25 was a smaller adult need.

1           And so the nice part about our building design  
2 is I have a variety of units that are different sizes,  
3 and so it allows me to take the local need of that  
4 community we're talking about building in and apply it  
5 to my building depending on the need.

6           So, as an example, for child and adolescent,  
7 we would take a 20-bed unit and an 18-bed unit and  
8 make that a 38-bed designated child and adolescent.  
9 If the need there was 10, as it was in chemical  
10 dependency, as we determined, then I would take one  
11 of my 10-bed units and strictly do that.

12           So that allows me to have multiple units with  
13 different sizes, allows me to take the identified need  
14 in the community and to utilize those units in order  
15 to meet the specific needs of that community rather  
16 than go to a community and say, you know, I have this  
17 one unit that's 10 beds and somebody has to fit into  
18 it. We specifically listen to the community and  
19 decide which populations those needs are.

20 Q.       From your standpoint -- or I would ask you  
21 what you know about why this project is located in  
22 Kingsport, Tennessee.

23 A.       Well, I think we'll probably talk a little  
24 later about the national study that we did. After  
25 having built five of these facilities and started them

1 from scratch -- no offense to the Certificate of Need  
2 process, but once we understand that there is a need,  
3 the hardest and most difficult thing that you have, to  
4 own and operate a psychiatric hospital, quite frankly,  
5 is to staff it.

6 And so how this Kingsport came on our radar  
7 was in our national study we did, it was ranked Number  
8 2 in the country for our ability to staff it. The  
9 reason we picked Kingsport was because it was the  
10 largest -- Sullivan County was the largest demographic  
11 population density, again, within which to set it so  
12 that I could, again, staff it.

13 Staffing is a huge component for us. Once we  
14 identify need, that is our -- that's our Number 1 as  
15 to whether we can be successful in these projects or  
16 not. There's needs all over the country, but staffing  
17 is of critical importance. And you have to have a  
18 population demographic large enough with which to  
19 staff from in order to be successful, and so Kingsport  
20 offered that to us.

21 Q. And I don't want to digress too much, but what  
22 are the steps that SBH takes in staffing up a new  
23 hospital once its built?

24 A. So we begin to recruit -- early on, we begin  
25 to recruit both physicians, nurses, mental health

1 techs, therapists, social workers, recreation  
2 therapists, back office, billing, collections,  
3 business office type folks as well, human resources,  
4 dietary, housekeeping, and maintenance. We go through  
5 all of those.

6 Part of when we evaluate a community, what's  
7 important to us is that in the region there are  
8 schools that are offering all of these disciplines,  
9 nursing schools, social work schools, psychology  
10 schools, sociology schools, medical schools, all of  
11 those with which, in that region, they are graduating  
12 those types of folks.

13 In our business, because psychiatric and  
14 substance abuse care is so specialized, there  
15 typically, nationally, aren't a bunch of folks just  
16 sort of running around with that experience so that we  
17 have to train a lot of those folks.

18 So, again, why that's important to us is we  
19 needed to know that there was a population demographic  
20 there that we could train and teach how to take care  
21 of patients for our facilities.

22 And our ramp-up -- you'll see in our pro  
23 formas or whatnot, our ramp-up is very, very slow, and  
24 that is on purpose. It has nothing to do with need.  
25 Our ramp-up has everything to do with your clinical

1 competence and ability to take care of how many  
2 patients the first month, the second month and the  
3 third month.

4 And so, as you see, we continue to recruit  
5 and hire the whole time. We don't hire 200 staff  
6 Day 1, because we only start, you know, one adult  
7 unit, as an example, at a time and we hire that staff  
8 and teach and train and start taking care of patients.

9 And then a few months later we open up the  
10 child and adolescent unit, as an example. A few  
11 months later we open up the geriatric unit. And so we  
12 step slowly into that process from a recruiting and  
13 from a hiring standpoint because it is very difficult.  
14 This is a very difficult population with which to  
15 treat.

16 Q. And you used the term "ramp-up." Would you  
17 explain just what you meant by that?

18 A. So each month we have an average. And, again,  
19 having built these facilities, we sort of know that  
20 there are, what I would call, certain stages within  
21 the growth and development of a new psychiatric  
22 hospital that it needs to stop and pause; it needs to  
23 stay at that level.

24 And so when we design our pro formas, our  
25 financial pro formas, you can see in those pauses --

1 what I call pauses -- where we stay at the same level  
2 for a month or two and sometimes three months so that  
3 the staff and the system are able to acclimate.

4 To move 30 patients or -- I'll use to move  
5 15 patients throughout the building, to take them  
6 to the gym, to take them to dinner three times a day  
7 for meals, to do that is very different for staffs  
8 systematically and programatically than to do 45  
9 patients on four different units or two different  
10 units.

11 And so every so often you have to pause and  
12 make sure that the design and the clinical systems are  
13 able to handle that. That's how you know you can then  
14 start growing and recruiting more staff and going to  
15 the next program.

16 Q. I wanted to ask you, when you talk about your  
17 facility -- let's take the design for SBH-Kingsport.  
18 Would you describe for the Court sort of what that  
19 facility will look like building-wise?

20 A. Sure. From the outside looking in -- we've  
21 probably shown some pictures -- it's a very unassuming  
22 building. A psychiatric hospital needs to be a  
23 therapeutic environment. It doesn't need to be a  
24 sterile hospital-type setting. These patients are  
25 already in distress and need a lot of light. They

1 need -- for example, I put carpet on the floors rather  
2 than that sterile VCT tile that you'd have at a  
3 medical/surgical hospital, as an example, because it  
4 softens the therapeutic environment.

5 Our buildings are designed for patients that,  
6 once they come in, it's a secure building, because we  
7 take both voluntary and involuntary patients. And we  
8 have a center courtyard within the facility that the  
9 building is built around that we are actually able --  
10 what it allows us to do -- and being an old rec  
11 therapist, I designed it this way. It allows me to  
12 take an involuntary patient and still get them outside  
13 and have fresh air but yet are still secure because  
14 they're there involuntary.

15 In addition, each of the units are designed  
16 specifically for those patients. So, as an example,  
17 our geriatric unit is designed as a square, where the  
18 nurses' station is in the center, because you have  
19 geriatric falls and you also have geriatric patients  
20 who like to wander when they're not in clinical  
21 programming. So we built a walking track around the  
22 nurses' station and we let our patients wander. If  
23 the building isn't designed that way for geriatric,  
24 it's less than optimal, as an example.

25 So what we have done is gone to each of these

1 units -- on the child and adolescent units, for  
2 example, and, actually, throughout the whole building,  
3 the walls are hardened. There's a different material  
4 that we use specifically so that the patients can't  
5 destroy the walls. Why is that important? Because  
6 these patients like to do things to distract from  
7 their clinical interventions and from the issues, the  
8 clinical issues that we are asking them to start to  
9 deal with in this setting.

10           So the physical environment is designed and  
11 built specifically to remove those barriers so that  
12 staff are safe and so that patients feel safe and that  
13 they're able to open up and begin to deal with their  
14 clinical issues, and we have found success in doing  
15 that.

16           And the way the building is designed is you  
17 literally just go around and there are specific units  
18 that go off. There will be a 20-bed unit going this  
19 way and a 12-bed unit going this way, as an example,  
20 with a central nurses' station. The reason we do a  
21 central nurses' station is for economies of scale with  
22 staffing.

23           So, again, you have mandated in some states  
24 and in other states staffing ratios, and so units can  
25 share staff, can share nurses, just like they share

1 physicians. It's designed in a way to get the best  
2 economies of scale as well.

3 The second reason it's designed the way it is,  
4 is because in our area, sight and sound are critical.  
5 To understand this patient population, the reason  
6 you're in a psychiatric hospital, you have shown  
7 significant crises. Attempted suicide or attempted to  
8 harm someone else or yourself is the majority of those  
9 patients.

10 Well, in that scenario, the building has got  
11 to be designed so staff can keep an eye on them  
12 because they will continue to try and hurt themselves  
13 or someone else, hence why they're in a hospital  
14 setting. It's that severity of the most violent, most  
15 aggressive and difficult patients. And so the design  
16 is that the nurses' station, as an example, can hear  
17 and see down each hallway in order to keep their eyes  
18 on the patient at all times.

19 Q. What type of treatment staff is typically  
20 available or will be available at SBH-Kingsport?

21 A. Our physicians are, you know, board certified  
22 or board eligible in both adult, child and adolescent.  
23 It just depends on what programs we're offering. We  
24 have physicians, psychiatrists. We have internal  
25 medicine for all of our history and physicals. We

1 have psychiatric nurses.

2 We actually have medical/surgical nurses as  
3 well, because on the geriatric units -- because,  
4 typically, a geriatric unit might have a medical  
5 comorbidity that needs to be treated, as well, in  
6 a freestanding -- can be treated in a freestanding  
7 setting in the geriatric units.

8 We have therapists, master's prepared,  
9 some licensed and some license-eligible. Master's  
10 prepared therapists and case managers. We have what  
11 we call mental health techs who are -- they are what  
12 we call direct care staff, working with the patient  
13 every minute of every day.

14 All of our patients in our buildings, at a  
15 minimum, have to be recorded and documented that they  
16 are safe and where they're supposed to be every  
17 15 minutes. The mental health tech is charged with  
18 the assignment of those patients and doing that every  
19 day.

20 And then the rest are business office, back  
21 office, human resources, dietary, housekeeping,  
22 maintenance, support staff.

23 Q. You mentioned having physicians or -- does SBH  
24 employ the physicians?

25 A. We do not. We have a very, very different

1 medical staff model than a lot of folks around the  
2 country, and it's worked very, very well for us. We  
3 have what's called an open medical staff model. It's  
4 part of -- interestingly, we think it speaks to the  
5 orderly development of health care because we allow  
6 local physicians to be credentialed in our facility  
7 and can admit and follow and see their own patients  
8 within our facility.

9           When we bring physicians -- and we often do  
10 when we open a new hospital, we recruit new physicians  
11 into the community, and we encourage those physicians  
12 to embed themselves in the community, as well, to be  
13 of support.

14           And so we have an open medical staff model  
15 which allows them to treat the number of patients that  
16 they choose to treat rather than employing them and me  
17 telling them the number of patients they're going to  
18 see in a day. It tends to allow me not to tell a  
19 physician how to practice medicine, and we like that.

20 Q.       In the Strategic Behavioral Health system,  
21 are there any board-certified child and adolescent  
22 psychiatrists who work at any of your SBH hospitals?

23 A.       Yes. There are -- I don't know the number  
24 off the top of my head, but every hospital that we're  
25 doing child and adolescent work, we have at least one,

1 if not two, three or four. We have a large number of  
2 board-certified child and adolescent psychiatrists  
3 within the company. We do a lot of children and  
4 adolescent work.

5 In North Carolina, for example, I have 256  
6 just child and adolescent beds. So I dare say, all  
7 of my psychiatrics in North Carolina are either board  
8 eligible for child and adolescent or board certified  
9 for child and adolescent.

10 Q. What are your plans with regard to having  
11 board-certified child and adolescent psychiatrists  
12 available at SBH-Kingsport?

13 A. Again, part of the -- we think part of the  
14 great orderly development of health care is when you  
15 have a psychiatric hospital what you have is enough  
16 revenue that allows me to recruit to a community and  
17 to bring in board-certified child and adolescent, if  
18 that was the case; if it was geriatric, a geriatric  
19 psychiatrist. And what it does is allows us to bring  
20 new resources to a community.

21 In Kingsport, that's exactly what our plan  
22 would be, because we do know and identified in our  
23 due diligence that there's a shortage of child and  
24 adolescent -- not only is there a shortage of beds,  
25 which we've demonstrated, but there's a shortage of

1 child and adolescent psychiatrists.

2 So we think that bringing new child and  
3 adolescent psychiatrists to the community to not  
4 only practice in our hospital but to practice in the  
5 community is a great way in which to help with the  
6 orderly development.

7 Q. And what, if any, outpatient services --  
8 well, let me just start with what, if any, outpatient  
9 services does SBH offer at any of its other  
10 psychiatric hospitals?

11 A. Except for North Carolina -- North Carolina is  
12 a special case in that there are -- they privatized  
13 the community mental health centers, if you will, and  
14 the community mental health centers in North Carolina  
15 became payors. And so there are literally hundreds of  
16 outpatient providers scattered and companies scattered  
17 throughout North Carolina for outpatient.

18 So in North Carolina we decided not to do  
19 outpatient and strictly do inpatient and partner  
20 with those outpatient providers. But outside of  
21 that, all of my hospitals offer what's called partial  
22 hospitalization services and intensive outpatient  
23 services.

24 Those are outpatient -- intensive outpatient  
25 services where the patient, for example, will come all

1 day long and care with us and go home in the evening  
2 and stay in their homes. In intensive outpatient,  
3 they might come three days a week, as an example.  
4 These are intensive outpatient services that are  
5 either step up, meaning they can start out in those  
6 programs, and if their clinical severity doesn't  
7 get better in those programs and they need to be  
8 inpatient, they can go to inpatient, or they can be,  
9 in more cases, step down from an inpatient to these  
10 programs.

11           It's an important step, because if you  
12 understand this patient population and understand that  
13 -- you know, I'll use an alcoholic as an example, who,  
14 when he's in my building, it's very easy for him not  
15 to drink. I'm not allowing him. I don't give him  
16 access to alcohol. Where you know you've had a  
17 clinical impact is when he goes home.

18           A partial hospitalization program allows him  
19 to go home the next day from discharge and not go and  
20 drink, not go to the bar. And if he does, by any  
21 chance, he's coming back the very next day and has a  
22 peer group in partial hospitalization with which to  
23 answer to as to whether he's clinically ready or not.

24           Partial and intensive outpatient offer great  
25 testing ground for patients to know where they are

1 in their care versus just having them inside of a  
2 psychiatric hospital and that be the only level of  
3 care. It's an important level of care to make sure  
4 they're safe, but as a step down, those programs,  
5 those outpatient programs are critical. They're also  
6 critical to prevent hospitalization in some cases,  
7 which is always a goal.

8 Q. So do you have to be -- do you have to enter  
9 those -- do you have to have been an inpatient first  
10 to enter both of those programs?

11 A. You do not. They're open to the public.

12 Q. And what is the referral source that would get  
13 them services?

14 A. Typically would be outpatient therapists,  
15 school systems, juvenile courts if it was kids,  
16 nursing homes. We have nursing homes that actually  
17 send -- and assisted living facilities might send us  
18 a geriatric patient for a day program and back to  
19 their facility at night, so -- hospitals. Hospitals,  
20 emergency rooms might have stabilized a patient,  
21 although not an optimal place for a psychiatric  
22 patient to be, but if they did get stabilized in the  
23 emergency department, they could go to a partial -- be  
24 referred strictly to our partial program. They don't  
25 have to go to inpatient just because that service is

1 available.

2 Q. You have heard Mr. Jackson today talk about  
3 crisis stabilization unit concept.

4 A. I have.

5 Q. What is your understanding of the crisis  
6 stabilization unit type operation?

7 MR. SWEARINGEN: I'm going to object to  
8 this testimony for a couple of reasons. One, to my  
9 knowledge, they don't operate any crisis stabilization  
10 units; and, two, this was never disclosed as an  
11 opinion that Mr. Shaheen was going to be offering as  
12 part of his testimony, and it's clinical in nature, I  
13 believe.

14 MR. WEST: It's also a business, Your  
15 Honor, if I may speak in response, the CSU business.  
16 Mr. Shaheen is in the psychiatric hospital business.  
17 It's been proposed as an alternative, apparently, to  
18 hospitalization. I think he can speak just as to his  
19 -- I'm not offering it for a clinical diagnosis. It's  
20 for his awareness of what a CSU does and what its role  
21 is in the system.

22 THE COURT: Well, when you say it's an  
23 opinion that has not been disclosed, he's not being  
24 offered as an expert at this point in time.

25 MR. SWEARINGEN: Well, I just don't think

1 any foundation has been laid for how -- they don't  
2 operate CSUs and so --

3 THE COURT: Well, I haven't heard that  
4 yet, and so that will be up to him to establish  
5 whether or not they do and what, if anything, he knows  
6 about it, and then, of course, you can cross-examine  
7 him about that.

8 MR. SWEARINGEN: Yes, Your Honor.

9 BY MR. WEST:

10 Q. Well, let me ask you that question. Does your  
11 company operate any CSUs?

12 A. Not at this current time.

13 Q. And, to your knowledge, does Mountain States?

14 A. No.

15 Q. And in your business are there CSUs in any of  
16 your markets?

17 A. There are.

18 Q. And in your experience how do your hospitals  
19 interact with the CSUs?

20 A. We are typically a referral source for the  
21 CSUs as a step down from the hospital. And we are  
22 also a receiving facility from the CSUs. We get  
23 patients referred to us from the CSUs as well.

24 A CSU -- every state is different in how they  
25 define what a CSU does. But as an overall, it is not

1 a licensed hospital. It does very similar services,  
2 but they have to be significantly different or you  
3 would be circumventing the Certificate of Need in  
4 those states. So it is a highly intensive service.

5 Over the last 27 years, I've probably worked  
6 with 10 or 20 CSUs around the country in my different  
7 hospitals because there is a direct relationship. Any  
8 good psychiatric hospital is embedded in a community  
9 and is designing its services and what it offers based  
10 on what the community has to offer.

11 So any good psychiatric hospital -- and over  
12 the last 27 years, you study what's in the community  
13 and build partnerships with those providers of other  
14 and lower levels of care, and it could be higher  
15 levels of care, too, depending on what you're doing,  
16 but different levels of care. And so it's important  
17 to be looking at the entire patient and being able  
18 to refer a patient into any level of care. It's  
19 important for a good psychiatric hospital to know all  
20 about that.

21 So I actually do know a tremendous amount  
22 about CSUs just because -- I choose not to offer those  
23 within my current company, but I have spent years  
24 working with CSUs.

25 Q. And are there any CSUs currently available

1 in Hawkins or Sullivan counties to your knowledge?

2 A. For adults only, because in the state  
3 of Tennessee, a child and adolescent CSU is not a  
4 regulatory statute. It doesn't exist. You can't  
5 open up a child and adolescent CSU in the state of  
6 Tennessee.

7 Q. Can you say where the CSU is? Do you know?

8 A. Actually, I think it's in Johnson City.

9 Q. That's not in Sullivan County, is it?

10 A. No, it's not.

11 Q. I know you have the map handy, but what is  
12 the service area of the proposed project for  
13 SBH-Kingsport, LLC?

14 A. It's Sullivan, Hawkins, Lee, Scott, and Wise.  
15 I think that's right.

16 Q. And those last three you mentioned are in  
17 Virginia; is that correct?

18 A. They are. They are.

19 Q. And what was your involvement in the CON  
20 application process in this case?

21 A. So Mike Garone, my director of development,  
22 and I had traveled to the community and met with  
23 stakeholders. He did the majority of that work. I  
24 just came in once or twice and met with folks. But  
25 when you -- when I started -- he started reporting

1 that information, and the folks -- all of the  
2 stakeholders that he met with were telling us what  
3 the needs were for, where the needs were from,  
4 those sorts of things, is when we determined that not  
5 only -- again, Number 1 for us is we needed Sullivan  
6 County because it's the largest demographic, largest  
7 population demographic with which to staff, again,  
8 just a critical piece to us for that.

9           When we looked at all of that, you know, we  
10 decided that those communities needed those services.  
11 And because the Certificate of Need asks you to define  
12 your service area, we chose that particular service  
13 area.

14           Interestingly, it was borne out by the  
15 chairman of the HSD when he described our service  
16 area, exactly what he thought was accurate, so we  
17 turned out to be correct, for someone who lived up  
18 in that area and understood the definition of service  
19 areas. So we were pleased to hear that when he  
20 described that in the hearing. So we think that  
21 that's the way in which we went about this.

22 Q.           Mr. Shaheen, how many times, to your  
23 knowledge, has SBH or its affiliated companies entered  
24 a new market for inpatient psychiatric services?

25 A.           Eight. Let me say eight hospitals, really

1 seven markets, because I have two in Las Vegas. So if  
2 you define a market as just a region, then it would be  
3 seven. But we have entered markets seven times within  
4 the last eight years.

5 Q. And what, if any, impacts have you observed  
6 or been able to perceive in those markets on other  
7 psychiatric providers, inpatient psychiatric providers  
8 from the SBH projects that have been developed or  
9 acquired?

10 MR. SWEARINGEN: I'm going to object,  
11 again, to the lack of foundation, Your Honor. To  
12 give you a sneak preview, I did ask this question to  
13 Mr. Shaheen in his deposition, and the answer he gave  
14 was that he spoke to somebody at another hospital out  
15 in Colorado. Well, that's hearsay. If he's done some  
16 sort of analysis since then, a foundation could  
17 perhaps be laid for it, but if he's only going to be  
18 offering us hearsay statements from other folks, then  
19 I don't think that's appropriate.

20 THE COURT: Well, I haven't heard yet, so  
21 it may be premature to make that objection, so let's  
22 see what his response is.

23 THE WITNESS: Sure. What we have seen  
24 in the markets that we have joined, and it's been  
25 similar in multiple markets, is that we actually

1 provide care and the way we provide care is  
2 significantly differently than some of the other  
3 providers in that market.

4 And so, in doing so, in order to  
5 contribute to the orderly development, we spend time  
6 with those competitors, as an example, talking about  
7 the way in which, for example, we respond to the  
8 emergency departments. We respond -- in Colorado  
9 Springs, Colorado, the average was three and a half  
10 hours' response time for a local psychiatric hospital  
11 to tell the emergency department whether they were  
12 going to accept a patient or not. Today that's  
13 45 minutes.

14 And the reason for that is we joined the  
15 community, we began responding within 45 minutes, and  
16 sat down with the community collaboratives and said  
17 this is -- in order to contribute to the orderly  
18 development, this is -- an appropriate response for a  
19 psychiatric hospital should be 45 minutes. Everybody  
20 in the community agreed, and so now all of the  
21 providers in that community are now responding within  
22 45 minutes.

23 In addition to that, each of those folks  
24 in those communities, we have seen significant access  
25 increase because of the way in which we go out and

1 actually market our services. We provide mobile  
2 clinical assessments out in the community where in  
3 some markets that wasn't being offered before.

4 So it increases access to care by having  
5 clinicians out in the community doing free clinical  
6 assessments to determine whether a psychiatric  
7 hospital is necessary, up to and including going to  
8 the emergency departments.

9 The effect that we've had in these  
10 communities is the competitors in those markets are  
11 now also starting to offer that same service, hence  
12 increasing access to care in that given market because  
13 there are more services available to the community to  
14 actually find out what mental health services they  
15 need.

16 Mobile assessment is a perfect example of  
17 it increases access to all mental health services, not  
18 just hospitals. 30 percent of the calls that we get  
19 go into the hospital, 70 percent do not. So all of  
20 those clinical assessments that we're out doing,  
21 70 percent of those are now being referred into the  
22 community for services.

23 So have we had an impact in access to  
24 care? Absolutely we have, because 70 percent now  
25 are getting a clinical assessment where they weren't

1 before in a lot of these markets, getting a clinical  
2 assessment to determine where they need to go. And  
3 30 percent need hospital services, but 70 actually did  
4 not.

5 Q. I don't think we've touched on this yet  
6 in your testimony, at Strategic Behavioral  
7 Health-Kingsport, what will be the inpatient  
8 psychiatric services that are offered, what types  
9 of units and so forth?

10 A. We have proposed to offer 38 child and  
11 adolescent inpatient hospital beds. We've proposed  
12 to offer 18 adult mental health psychiatric beds,  
13 inpatient beds. We've proposed to offer 16 geriatric  
14 inpatient psychiatric beds, and we've proposed to  
15 offer 10 chemical dependency, specific adult chemical  
16 dependency beds for folks dealing with substance  
17 abuse, and ability to do medical detox within those  
18 10 beds, for the community.

19 That breakout of 38, 18, 16, and 10 is  
20 specific to our on-the-ground work, talking with folks  
21 about bed availability, talking about -- because as an  
22 example, the only child and adolescent provider in the  
23 entire area is the 12 beds at Woodridge.

24 And so why you see us saying 38 -- again, the  
25 idea of us filing these numbers was to contribute to

1 the orderly development of care in this community by  
2 not duplicating.

3 If there's a large child and adolescent  
4 need, it's why there's a -- there's less child and  
5 adolescent beds than there are adult beds, so you see  
6 us have less adult beds. That was the whole purpose  
7 of how that process goes. It was specific to the  
8 market.

9 Q. And how many total beds would the hospital  
10 have?

11 A. 72.

12 Q. You want to run through that math again?

13 A. Is that right? 38, 16, 18, and 10. Is that  
14 right?

15 Q. Well, in any event, you're not going to have  
16 more than 72 beds, are you?

17 A. No.

18 Q. And your largest will be child and adolescent?

19 A. Correct.

20 MR. WEST: If I may take just a moment,  
21 Your Honor. I need to get an exhibit to offer to  
22 Mr. Shaheen.

23 THE WITNESS: 28. Sorry. That math  
24 doesn't work. It's 28. Sorry.

25 THE COURT: When he comes back to the

1 podium, why don't you correct yourself?

2 THE WITNESS: I'm sorry. I tried to do  
3 it off the top of my head.

4 BY MR. WEST:

5 Q. Mr. Shaheen, do you have any additional  
6 testimony to offer?

7 A. I do. Sorry. It's 28 child and adolescent.  
8 It's not 38. The rest of the numbers are correct.

9 MR. SWEARINGEN: Object to the leading.

10 THE WITNESS: Lots of numbers running  
11 around in my head. I apologize.

12 BY MR. WEST:

13 Q. Before we go any further on this, in your  
14 testimony, Mr. Shaheen, I wanted to -- you had spoken  
15 -- or testified earlier about the ramp-up period.

16 A. Yes.

17 Q. And I wanted to show you an exhibit, which I  
18 believe is Exhibit 11 in the big notebook, but I  
19 brought copies of it.

20 MR. CHRISTOFFERSEN: In this notebook,  
21 Bill?

22 MR. WEST: Yes. It was a deposition  
23 exhibit.

24 If I may approach the witness, Your  
25 Honor.

1 THE COURT: Yes.

2 BY MR. WEST:

3 Q. Mr. Shaheen, I've shown you what I -- let  
4 me just double-check. I believe it's Exhibit 11 to  
5 the -- in the big notebook of exhibits that we have  
6 from the depositions. Can you identify this document?

7 A. I can. It's an Excel spreadsheet that is our  
8 -- has been our template that we utilize to do pro  
9 formas for not only new psychiatric hospitals but also  
10 management units or and/or smaller units. It's the  
11 template with which we use to do that.

12 Q. And what is the source of this spreadsheet  
13 originally?

14 A. I created it nine or ten or eleven years  
15 ago as a tool to utilize to decide, from a business  
16 perspective, whether the financial model worked.

17 Q. You might need to speak up just a little bit.

18 A. Okay. I created it ten or eleven years ago or  
19 so to give me a tool to evaluate whether a project had  
20 financial feasibility or not.

21 Q. And each project that you do, do you  
22 personally input additional data, or how is that  
23 handled?

24 A. I did for a lot of years, and then over the  
25 last several years, I've actually handed that off to

1 my development staff.

2 Q. So in this case it would have been Mr. Garone?

3 A. It would have, yes.

4 Q. But you've seen this spreadsheet before?

5 A. I have.

6 Q. And what's the date on it?

7 A. This particular date says 13 October 2014.

8 Q. And up to the left of that, what does it say?

9 A. Kingsport.

10 Q. Are there any problems that you've identified  
11 from the front page of this spreadsheet?

12 A. Not from the front page. Well, again, there's  
13 a glaring that we've -- we've recognized a length of  
14 stay formula -- or not formula, but entry that is not  
15 accurate. It doesn't affect the first page, first  
16 year, because that's build year. There are no  
17 patients associated with that, but on Year 1, it does  
18 affect that.

19 Q. And what steps did you take to correct that?

20 A. Well, once we realized that that number was  
21 not -- shouldn't have been there, was not accurate --  
22 I guess I can explain why that -- how that happens.  
23 First of all, this is a template that we use. And  
24 so Mr. Garone asked me for a template, and I sent him  
25 one where I was working on a geriatric psychiatric

1 hospital proposal and looking at that. And the  
2 average length of stay for a geriatric psychiatric  
3 facility is about 12 days nationally as well as within  
4 our company, and so that's where the 12 was  
5 pre-plugged.

6           There are plug -- the way the formulas are  
7 written is the length of stay is put in as an accurate  
8 length of stay and then the admission numbers are put  
9 in in order to create an average daily census. The  
10 way we look at this is very different -- and a lot of  
11 people like to look at numbers of admissions and cases  
12 and that sort of stuff.

13           Once we've established that there is a need,  
14 the way we build our pro formas are based upon patient  
15 census, because patient days are how you staff,  
16 patient days are how you ramp up a facility.  
17 Admissions isn't how you do that.

18           And so what you do is you hard-code what is  
19 the pace at which you want to grow this facility. So,  
20 for example, you see 3.1 the first month, 6.4, 11.6?  
21 That is generated by entering the average length of  
22 stay number and the admission number automatically  
23 calculates what that is, and so you move that  
24 admission number to get to the desired ramp-up for  
25 patient days, because patient days are truly what we

1 operate off of, because the determination that Day 1  
2 there's a need for 72 beds, in our minds, has already  
3 been established. And so ours is about the way in  
4 which we're clinically going to ramp up and the amount  
5 of staff we're going to hire. So we're always looking  
6 at 3.9, 6.4.

7 In this particular case, it was overlooked  
8 on the initial application, that the 12 was left in  
9 there. When we made the change, you'll see that the  
10 patient days did not change, and that, again, was  
11 because that's how we built a pro forma, was on  
12 patient days, not on admissions.

13 Q. When you use the expression "patient days,"  
14 could you define for the Court what a patient day is?

15 A. When a patient is in a psychiatric hospital at  
16 midnight, it's counted as one patient day. So if ten  
17 patients are in at midnight, it's ten patient days for  
18 that given day times the number of days in the month.

19 And then this -- the way this formula works is  
20 it picks the months, starting in the month -- so, for  
21 example, there's 28 days in February, and so it will  
22 take 28 days, times what the average census would be,  
23 in order to get the patient days.

24 And patient days -- again, census drives  
25 staffing. It drives -- patient days drive every

1 metric for us. Admissions do not drive that.

2 Q. When you were mentioning those numbers, .3.1  
3 and so forth, what page are you on?

4 A. I'm on 0274, Year 1, when the facility starts,  
5 Column 1, title "Column 1," 3.9, 6.4, 11.6, 16, 19,  
6 24, 27. You can kind of see how we -- and I was  
7 mentioning the leveling off. You can see the two 34s,  
8 as an example, is a good pace, the two 38s, again,  
9 pausing for a minute to determine what additional  
10 staff, to determine how the program needs to change,  
11 to determine in order for this to be a safe and  
12 therapeutic environment for the patients.

13 Q. And was this spreadsheet utilized in preparing  
14 the financial projections for the CON application?

15 A. Actually, it was. Yes.

16 Q. And, again, what is -- you're the original  
17 author of this Excel -- I assume it's Excel, right?

18 A. It's an Excel spreadsheet, yes.

19 Q. And how did you come up with this format and  
20 these line items?

21 A. You know, 10 years ago -- I mean, just having  
22 worked with a variety of the tools over the previous  
23 17 years, I guess, really -- I realized when we  
24 created this what the important metrics were that you  
25 needed to know and understand about your business.

1           You know, you see payor mix down there, you  
2 see what you pay staff and what you pay staff by  
3 position, because that's an incredibly important  
4 distinction. You'll pay a therapist significantly  
5 more than you'll pay a mental health tech, but yet  
6 you'll have dramatically more mental health techs  
7 than you will have therapists because of the ratio of  
8 therapist to patient to mental health tech to patient.

9           So it's built so that each of those  
10 disciplines, each of those different areas are staffed  
11 according to, again, whether a state has a defined  
12 ratio or not, or our own clinical ratios that we want  
13 to operate from, and it does it by area.

14           So nurses, as an example, is a different  
15 ratio, and nurses also make significantly more, so you  
16 want to capture -- make sure not to just do an average  
17 hourly rate of 18-something an hour across the board.  
18 It's more accurate to pick, literally by discipline,  
19 how many staff that's going to be and what they're  
20 going to get paid.

21 Q.       Does your company utilize this template  
22 spreadsheet in developing its other projects?

23 A.       Every single one.

24 Q.       And has Strategic Behavioral Health, LLC, ever  
25 had to close a hospital of its own?

1 A. No.

2 Q. Has it ever had one that it had to sell off?

3 A. No.

4 MR. WEST: Okay. Your Honor, if I may, I  
5 would like to make that whatever exhibit number we're  
6 up to now.

7 THE COURT: I think this will be 1.

8 MR. WEST: I think we have a new  
9 numbering format here.

10 MR. JACKSON: I think, Your Honor, if  
11 it's all right with you, maybe we'll just keep the  
12 number it was given, which I think was 11, so we'll  
13 have -- Exhibit 9 has been admitted, which is the CON  
14 application which we have to correct, and then this  
15 will be Exhibit 11, if that's all right. They'll be  
16 out of order. I mean, they'll be crazy numbers like  
17 that, but I think that will be easier than trying to  
18 start with 1 and renumbering, if it's okay with Your  
19 Honor.

20 MR. WEST: Your Honor, it's going to seem  
21 a little -- I'll defer to Mr. Christoffersen.

22 MR. CHRISTOFFERSEN: No need to defer to  
23 me. I was just going to point out that the parties  
24 have been numbering these throughout the depositions.  
25 And sometimes in these cases when they get renumbered,

1 it becomes confusing, so this way of doing things is  
2 something that the attorneys have found has worked.

3 MR. WEST: I agree. I think the net  
4 effect will be, Your Honor, when you see the proposed  
5 findings and conclusions, the exhibit numbers may  
6 jump around a lot, but it's tied more to when they  
7 originally were -- most of them originally were made  
8 exhibits, and that's perfectly fine with me.

9 THE COURT: So at some point we will have  
10 a 1 through 10?

11 MR. SWEARINGEN: No, Your Honor, there  
12 will be gaps.

13 THE COURT: What about somebody reading  
14 this after, perhaps? Is it going to make sense? Will  
15 the transcript make sense?

16 MR. SWEARINGEN: Yeah. It doesn't  
17 usually cause a problem because they aren't any of the  
18 wiser that there was not 1 through 8, so really all  
19 that's important is that we all agree and know how the  
20 numbering structure is going to work. Again, just for  
21 preparation purposes, it makes it so much easier just  
22 to pre-number everything. That way when we're, you  
23 know, in the heat of discussion, we know exactly --  
24 not having to try to re-learn a new list of 1 through  
25 15. But, again, it's completely up to Your Honor.

1 MR. JACKSON: And at the end of the  
2 case, I would suggest we'll get together and put  
3 together an index for Your Honor that will be very  
4 easy to understand. The following exhibits were  
5 admitted, it will be Exhibit 9, CON application;  
6 Exhibit 11, spreadsheet, et cetera.

7 MR. WEST: We'll have an index.

8 MR. JACKSON: Right. We'll have an  
9 index.

10 THE COURT: And I understand that. It  
11 just seems -- I'm not sure I've ever done that, where  
12 at the end of the hearing there may not be an Exhibit  
13 1, 2, 3; it may not run chronologically.

14 MR. JACKSON: That's right. I have  
15 done it before, and I've done it both ways, and we've  
16 renumbered exhibits. And I do find that this is the  
17 easier way at the end of the day. And the only people  
18 who will -- if anyone's looking at this later, as  
19 Mr. Swearingen suggested, they really won't care that  
20 there wasn't an Exhibit 1 through 8 because they'll  
21 just be referring to Number 9, Number 11, whatever.

22 THE COURT: Okay. Well, I've never done  
23 it that way, but I'll trust you that that will work.  
24 So I'll have to keep from saying the first marked  
25 exhibit. I'll just simply say that Number 11 will

1 be marked now as an exhibit. Will that suffice for  
2 everyone?

3 MR. WEST: Yeah. My only question was,  
4 since we already have them in the notebook, but I  
5 think it is better to go ahead and introduce them at  
6 trial. So if you'll hand that to the reporter.

7 Your Honor, I believe my witness may be  
8 here, so if I could have a few minutes.

9 THE COURT: Okay. Just to finish up on  
10 this, she's going to put -- so that she's clear too,  
11 she's going to put "Number 11" on that exhibit, and  
12 let me just identify it. It is an Excel spreadsheet  
13 for the SBH-Kingsport hospital, and it has a date of  
14 October 13, 2014.

15 (Marked Exhibit No. 11.)

16 MR. WEST: If I may suggest, this may  
17 be an appropriate time to break for lunch. I've got  
18 to speak with this individual anyway, if that's all  
19 right. If that's all right with my opposing counsel.

20 THE COURT: Okay. It's right at noon, so  
21 I think that will be fine. Can y'all be back by 1:00?

22 MR. WEST: Yes, sir.

23 MR. SWEARINGEN: And just so we're clear  
24 on the plan, the plan is Mr. Shaheen will step down  
25 and --

1 MR. WEST: Yeah. And if that is  
2 Dr. Elliott, he'll take the stand.

3 THE COURT: So I'm clear, you have an  
4 expert you want to put on now?

5 MR. WEST: Well, he's not an expert.  
6 He's actually a fact witness, but he is a physician.  
7 He's actually a psychiatrist.

8 THE COURT: So he had some time  
9 constraints?

10 MR. WEST: Yes, and he's traveling.

11 THE COURT: And you're going to take him  
12 out of order, essentially?

13 MR. SWEARINGEN: And I don't have a  
14 problem. I just wanted to make sure. So when we come  
15 back from lunch, we'll start, and then we'll come back  
16 to Mr. Shaheen?

17 MR. WEST: Yeah.

18 THE COURT: All right. That's fine.

19 (Lunch recess observed.)

20 MR. WEST: We would call Dr. Hal Elliott  
21 to the stand.

22 THE COURT: All right.

23 HAROLD ELLIOTT, MD  
24 was called as a witness, and after having been duly  
25 sworn, was examined and testified as follows:

DIRECT EXAMINATION

1  
2 BY MR. WEST:

3 Q. Dr. Elliott, would you state your name and  
4 address for the record, please, sir?

5 A. Okay. My name is Harold Elliott. My address  
6 is 122 Morris Lane, Gray, Tennessee 37615.

7 Q. And are you in the process of relocating?

8 A. Yes.

9 Q. And where are you relocating?

10 A. To Ann Arbor, Michigan.

11 Q. And what is the purpose of your relocation?

12 A. I was formerly the program director at East  
13 Tennessee State for the residency program, psychiatry  
14 residency program, and I'm going to start a new  
15 residency program in affiliation with Michigan State.

16 Q. For their medical school?

17 A. Yeah, for the -- yes.

18 Q. And when did you stop working for ETSU?

19 A. I was there until June 19th of 2015.

20 Q. So just a few weeks ago?

21 A. Yeah. Right.

22 Q. And would you describe for the record what  
23 your job duties were there? Well, let me back up a  
24 step.

25 Can you state your educational background and

1 prior job history?

2 A. Okay. I'm originally from South Carolina. I  
3 went to Davidson College where I got a bachelor's  
4 degree, and I got my MD from Medical University of  
5 South Carolina in Charleston.

6 I did my residency at University of North  
7 Carolina, Chapel Hill. I'm board certified in adult  
8 psychiatry and subspecialty boarded in psychosomatic  
9 medicine or consult liaison psychiatry.

10 I previously was on the faculty at Wake Forest  
11 University where I was the program director for the  
12 residency program there, and recently was the program  
13 director for the psychiatry residency at East  
14 Tennessee State.

15 Q. When did you come to East Tennessee State in  
16 that regard?

17 A. It was 2011.

18 Q. And in the context of your job duties -- could  
19 you describe your job duties at ETSU, what all you  
20 did?

21 A. Sure. I had a 50 percent time administrative  
22 and 50 percent time clinical appointment. And for the  
23 administrative appointment I was the director of the  
24 psychiatry residency program, and I also did clinical  
25 work where I was the inpatient attending doctor on the

1 Spruce Unit at Woodridge and I was seeing outpatients  
2 in the Department of Psychiatry.

3 Q. And so when you say the Spruce Unit at  
4 Woodridge, that's the geropsychiatric unit?

5 A. The gero -- right.

6 Q. At Woodridge Hospital?

7 A. Right. Correct.

8 Q. And did you have staff membership there at  
9 JCMC, Johnson City Medical Center?

10 A. Yes. Yes.

11 Q. Describe, if you would, your patient load at  
12 both places, the hospital and the clinical program,  
13 school.

14 A. At Woodridge Hospital, just like all the other  
15 faculty members, I covered weekend call, but also for  
16 the last two years, I was spending -- I was covering  
17 about 25 to 30 percent of the inpatient time at -- on  
18 the Spruce Unit and that continued until I left.

19 Q. And when was the last day you treated a  
20 patient at Woodridge?

21 A. I don't remember exactly, but I think it was  
22 the first week in June at some point.

23 Q. Of 2015?

24 A. Of 2015.

25 Q. So you were actually somebody who's been

1 working at Woodridge?

2 A. Right. Correct. For three and a half, four  
3 years, yeah.

4 Q. And 30 percent of time, what does that mean in  
5 terms of time of day or amount of hours per month?

6 A. Well, we would take weeks. And so in 2014, I  
7 was the primary backup for the regular doctor who was  
8 on the Spruce. So he would spend three weeks on the  
9 unit covering, then I would spend a week at a time.  
10 So I did a little more than one out of every four  
11 weeks. And then in the last year, when we lost our  
12 primary inpatient doctor, all the faculty members  
13 covered, and it ended up being about once every four  
14 to five weeks. And we spent a week at a time full  
15 time.

16 Q. Full time at the hospital?

17 A. Yes. Stay there until all the patients were  
18 seen.

19 Q. All right. So you're familiar with the  
20 operations of --

21 A. Yes.

22 Q. -- Woodridge at the Spruce Unit?

23 A. Right.

24 Q. In May and June, prior to your leaving that  
25 practice, what has been the -- what have you observed

1 about utilization at Spruce?

2 A. For the most part, we were staying full. I  
3 mean, there were 14 beds, and my recollection is that  
4 most days we had 14 patients in 14 beds. Usually,  
5 when we discharged maybe two or three patients, by the  
6 next day they were filled -- the beds were filled back  
7 up again.

8 Q. All right. And could you describe for the  
9 record your -- the clinical practice that you had at  
10 the medical school?

11 A. I saw outpatients there, regular private  
12 patients, and I would see them about two days a week.

13 Q. And so do you still practice there?

14 A. Oh, no. No. I stopped. I saw my last  
15 patient, I think, on June 18th.

16 Q. And what became of your patients, as far as  
17 you know, after you left?

18 A. Well, it was -- one thing, because of  
19 the shortage of psychiatrists that we had in our  
20 department -- we had maybe five or six psychiatrists  
21 leave in the last 18 months or so -- we couldn't  
22 see -- they could not absorb the patients that I  
23 had, so I had to refer those patients out to other  
24 providers.

25 Q. And where did they go?

1 A. We gave them the name for Frontier Health, but  
2 most of them couldn't get into Frontier, at least they  
3 couldn't get in to see a doctor for months. Several  
4 went to outpatient psychiatrists in the area who might  
5 have been taking patients, and there was a limited  
6 number of those. And I had some who had to go a long  
7 way away to get somebody to see them.

8 MR. JACKSON: Your Honor, please, I just  
9 want to object to this line of questioning and move to  
10 strike on the basis that the testimony that's just  
11 been elicited is about a shortage of psychiatrists at  
12 East Tennessee State University causing a problem in  
13 patients being seen by psychiatrists. It is not  
14 pertinent to the issue we're here about.

15 MR. WEST: Your Honor, if I may, we've  
16 already heard argument from Mr. Jackson about the  
17 systemic issues in East Tennessee. And one of the  
18 things that has surprised me -- one of the things that  
19 Dr. Elliott is capable of testifying factually about  
20 is that ETSU itself is a provider, through its  
21 psychiatric department, the ETSU medical school is a  
22 provider of outpatient services. And if there are  
23 problems or shortages in that department, then that's  
24 one more thing that affects the overall system's  
25 capability of handling the demand and the load for

1 psychiatric services. So I think it's highly relevant  
2 to this case. And this is a gentleman who has factual  
3 experience with it.

4 MR. JACKSON: If I may, Your Honor -- and  
5 I don't mean to take up too much time objecting, but  
6 another objection that I would like to lodge, though,  
7 is that this witness was identified as -- along with  
8 anyone else who wrote a letter of support -- as being  
9 someone who has knowledge as evidenced in their  
10 letters of support.

11 What he's testifying about now was not  
12 contained in his letter of support, so we've had no  
13 notice of this line of inquiry. It's also, basically,  
14 expert testimony. I would submit he's being asked to  
15 give opinions, I suspect, about these issues which  
16 require expertise. So for all of those reasons, but  
17 principally relevance, we would object.

18 THE COURT: He's on your witness list?

19 MR. WEST: Yes. And we've notified them  
20 about him since way back in 2014.

21 THE COURT: All right. I'm going to  
22 overrule your objection, and I'll give the testimony  
23 whatever weight I deem...

24 MR. JACKSON: Thank you, Your Honor.

25 MR. WEST: Thank you, Your Honor.

1 Frankly, I forgot what my last question  
2 was to him. Can you re-read it, please, ma'am?

3 (The requested testimony was read back by  
4 the court reporter as follows:

5 "Question: And where did they go?"

6 BY MR. WEST:

7 Q. Dr. Elliott, you've heard of the CON  
8 application for SBH-Kingsport, LLC, haven't you?

9 A. Yes.

10 Q. And last June, did you write a letter in  
11 support?

12 A. I did.

13 Q. Let me show you what's been marked as  
14 Exhibit 207 and ask you if you can identify that,  
15 please, sir.

16 A. Yes. This was the letter I wrote, I guess it  
17 was in June of 2014.

18 Q. Okay. And would you take a moment and look at  
19 that letter, and I want to ask you some questions  
20 about it.

21 A. (Reviewing document.) Okay.

22 Q. Is there anything in that letter that you  
23 would change?

24 A. There's nothing there that I would change.  
25 There might be some things that I might amend based

1 on things that have happened in the last year in terms  
2 of child and adolescent services.

3 Q. What are those?

4 A. Well, over the last year, I was the program  
5 director for the residency, and we had just -- we  
6 had just come off probation. And we didn't get that  
7 notification until, I think, March that we were going  
8 to come off probation.

9 Q. March of what year?

10 A. Of 2015.

11 Q. This year?

12 A. Yeah, just this year. We'd had a site visit  
13 the year before, but it took them a year to get back  
14 to us. One of the big issues that has come up in the  
15 last year is with the closing -- well, the Willow Unit  
16 has not closed at Woodridge, but they don't have a  
17 child and adolescent psychiatrist to staff that unit,  
18 and so therefore it's not a viable training site for  
19 the psychiatry residents.

20 So for the last year, we have really struggled  
21 to find a viable child and adolescent experience for  
22 our residents. They have to have at least two months  
23 of full-time -- called full-time equivalent of child  
24 and adolescent experience for us to maintain our  
25 accreditation.

1           And over the last year, I've had a constant  
2 dialogue with the administration and with my own chair  
3 that if we didn't obtain that in a way that I thought  
4 met the requirements, that I would have to notify the  
5 accrediting body, the ACGME.

6           And just before I left, I learned that we were  
7 not going to have adequate resources, and I did notify  
8 the ACGME that we were not in compliance with the  
9 requirements for a child and adolescent experience.

10 Q.       What is the ACGME? What does that stand for?

11 A.       Boy, I should know this. The ACG -- it's  
12 basically for accreditation of residency programs.  
13 I'm so used to saying the letters. But basically it's  
14 for accreditation residency programs. And much like  
15 the JCAHO would come into the hospital, they come in  
16 and do site visits and make sure you're maintaining  
17 the appropriate resources for your residents.

18 Q.       And what is the function in the residency  
19 training program of, say, a child -- a board-certified  
20 child and adolescent psychiatrist? What role would  
21 they play in the residency program?

22 A.       In order to get appropriate -- it's the  
23 Accreditation Council for Graduate Medical Education.  
24 Sorry.

25           In order to get accreditation and credit if

1 you're doing a residency program for having child and  
2 adolescent, you have to have a supervising  
3 board-certified child and adolescent psychiatrist.

4 So if we don't -- if there's an experience,  
5 even though a resident might be seeing adolescents and  
6 children, if you don't have supervision by somebody  
7 who is board certified, then it doesn't qualify.

8 Q. All right. And, Dr. Elliott, when you sent  
9 this letter of June 24th to Ms. Hill, was it your  
10 intention to communicate this information to the HSDA?

11 A. Yes.

12 MR. WEST: Your Honor, I'd like to make  
13 this the next exhibit -- or Exhibit Number 207.

14 THE COURT: Can I see a copy so I can  
15 identify it for the record? It's not in this book,  
16 right?

17 MR. WEST: I don't believe so, no. This  
18 was one we exchanged on Friday.

19 THE COURT: The book ends at 90.

20 MR. WEST: Yeah.

21 THE COURT: The next exhibit is  
22 Exhibit 207, which is a June 24th, 2014, letter from  
23 Dr. Elliott to Melanie Hill, executive director of the  
24 Tennessee Health Services and Development Agency.

25 (Marked Exhibit No. 207.)

1 BY MR. WEST:

2 Q. Dr. Elliott, what, if anything, have you heard  
3 about the establishment of an adolescent CSU in --  
4 crisis stabilization unit in Washington County or  
5 elsewhere in East Tennessee?

6 A. I haven't heard any -- you mean through the  
7 department?

8 Q. Yes.

9 A. Nothing. I've never heard that was even a  
10 possibility.

11 Q. And do you know what a CSU is?

12 A. Crisis stabilization unit.

13 Q. Right. So are you familiar with the function?

14 A. The concept, yeah.

15 Q. How would you compare that to inpatient  
16 psychiatric hospital care?

17 A. Well, a crisis stabilization unit, my  
18 understanding is that it's a place where there is very  
19 short-term treatment for patients in crisis and they  
20 stay in a facility for maybe two to three days, but  
21 it's not a full-service inpatient facility with things  
22 like group therapy and teachers and things like that  
23 for children and adolescents. It's more of a place --  
24 intermediate place to go if a kid is in a crisis or  
25 patient is in a crisis.

1 Q. Dr. Elliott, why are you testifying in this  
2 case?

3 A. I feel a responsibility to the people of  
4 that area and a responsibility to my residents who I  
5 recruited and taught over the last four years. And my  
6 concern was that we're already in a situation where we  
7 don't have adequate resources to serve the population  
8 we have, and this is a chance to expand the service to  
9 the people of the area.

10 But my biggest concern was that I wanted to  
11 have these kinds of resources available for education  
12 for the residents. These are -- you know, a full  
13 spectrum of child and adolescent services is something  
14 this area doesn't have and, to my knowledge, has never  
15 had.

16 Q. And how many child and adolescent beds does  
17 Woodridge Psychiatric Hospital have?

18 A. They have -- they have, I think, 10. I'm  
19 not -- I'm not -- I think 10 to 12. But like I  
20 said, they're not seeing a child and adolescent  
21 psychiatrist. It's a non-board-certified person.  
22 It's a med/psych doctor, actually.

23 Q. Do you know what building at Woodridge those  
24 beds are in?

25 A. It's in -- there's a main building, and it's

1 on Willow Unit. It's a branch.

2 MR. WEST: That's all the questions I  
3 have at this time, Your Honor.

4 THE COURT: Cross-examination?

5 CROSS-EXAMINATION

6 BY MR. JACKSON:

7 Q. Good afternoon, Dr. Elliott.

8 A. Good afternoon.

9 Q. I represent Mountain States Health Alliance in  
10 this case. Now, as I understand it, you have ended  
11 your medical practice in the Tri-Cities; is that  
12 right?

13 A. Right. Correct.

14 Q. And are you actually, literally, in the middle  
15 of your move?

16 A. I'm in the middle of the move now.

17 Q. So from here you're going to keep on driving  
18 to Michigan?

19 A. Exactly. I'm going to be -- yeah.

20 Q. And you know that -- you know Dr. Goodkin,  
21 right?

22 A. Yes.

23 Q. And what is his role?

24 A. He's the chairman of the department.

25 Q. The chairman of your department?

1 A. Uh-huh.

2 Q. He's the person you reported to --

3 A. Correct.

4 Q. -- until you left the university?

5 A. Correct.

6 Q. And were you aware that he's submitted an  
7 affidavit in this case?

8 A. Yes.

9 Q. And you know that when this matter came  
10 before the Agency, ETSU took a position against the  
11 application, right?

12 A. Correct.

13 Q. And so you, here today, are speaking for  
14 yourself, right?

15 A. Correct.

16 Q. You're not speaking on behalf of ETSU,  
17 correct?

18 A. Correct.

19 Q. You're not speaking on behalf of the  
20 Department of Psychiatry, correct?

21 A. Correct.

22 Q. And, in fact, you're not speaking as someone  
23 who's going to be practicing in Tennessee in the  
24 future?

25 A. That's correct.

1 Q. You'll be practicing in Michigan, right?

2 A. Correct.

3 Q. Okay. And you know that over the past few  
4 months, Woodridge -- you mentioned this lack of a  
5 child and adolescent psychiatrist.

6 A. Correct.

7 Q. You know that there's been an effort to  
8 recruit somebody, right?

9 A. Yes.

10 Q. And you know that these efforts to recruit  
11 specialty physicians takes some time, don't they?

12 A. Yes.

13 Q. And particularly somebody with that  
14 particular skill-set. There's not a huge number of  
15 board-certified child and adolescent psychiatrists out  
16 there, true?

17 A. It's a big, big shortage.

18 Q. And attracting them -- I love the Tri-Cities,  
19 so don't take this the wrong way, but attracting them  
20 to some areas of the country are harder than others,  
21 right?

22 A. Much more difficult to recruit to rural areas.

23 Q. Okay. And you don't deny or dispute that that  
24 effort has been ongoing, right, to recruit somebody?

25 A. From the department, that's the only one I

1 have firsthand knowledge of, not being successful.

2 Q. You know that over the years, Woodridge and  
3 ETSU have had a cooperative relationship?

4 A. You have to define "cooperative."

5 Q. Yeah. Sure. I understand. Any relationship,  
6 you have bumps and what have you.

7 A. Yeah.

8 Q. But Woodridge and the Department of Psychiatry  
9 at ETSU work together on a lot of things?

10 A. They do attempt to work together on a lot of  
11 things.

12 Q. And you know, for example, Woodridge is  
13 subsidizing 10 residency spots at ETSU, right?

14 A. That's not exactly right. They have the  
15 funding available for 10. There are 20 residents.  
16 The Veterans Administration pays for approximately 13.  
17 There is funding -- and this is what I deal with.  
18 This was my job. So we get another funding for maybe  
19 one or two of those, and then Mountain States pays for  
20 the remaining six. But they have enough that if we  
21 billed them for more, they have that available.

22 Q. I see. Okay. Thank you for the correction.  
23 But you would agree that Mountain States, each year,  
24 is contributing towards the cost of residents at ETSU,  
25 right?

1 A. Yes.

2 Q. In the Department of Psychiatry, right?

3 A. Correct.

4 Q. And specifically you said it was six resident  
5 spots, but they're budgeted up to ten; is that  
6 correct?

7 A. Up to ten, correct.

8 Q. And the ten would be \$450,000? Is that what  
9 subsidizing ten would cost?

10 A. I don't -- it's confusing to know how much  
11 that is, because it goes to the administration, and  
12 there's also how much they receive from the  
13 government. So I don't really know exactly.

14 Q. If we have evidence in this case from somebody  
15 else that says it's 450,000, would you have any reason  
16 to dispute that?

17 A. I wouldn't be able to dispute that.

18 Q. Okay. And you know there are also,  
19 annually -- Woodridge is also annually providing some  
20 funding to help support some faculty positions, true?

21 A. Correct.

22 Q. And is that \$45,000?

23 A. That sounds about right.

24 Q. You haven't actually reviewed the entire CON  
25 application that we're here about, have you?

1 A. No.

2 Q. You haven't looked at any of the plans that  
3 SBH has prepared, if they have prepared any, about  
4 what they're going to do exactly, true?

5 A. As far as seeing the actual documents?

6 Q. Yes, sir.

7 A. No.

8 MR. JACKSON: That's all I have. Thank  
9 you.

10 MR. WEST: If I may, Your Honor, I have  
11 some redirect.

12 REDIRECT EXAMINATION

13 BY MR. WEST:

14 Q. Dr. Elliott, you were asked by Mr. Jackson  
15 about residency spots.

16 A. Correct.

17 Q. Have you personally communicated with Mountain  
18 States -- while you were in your job at ETSU, did you  
19 personally communicate with any Mountain States  
20 personnel about residency issues?

21 A. Yes.

22 Q. What was the nature of your communications  
23 with them?

24 A. There were frequent meetings. And I'm not  
25 sure how much detail you want me to go into, but when

1 I first arrived at ETSU, the program was in  
2 significant difficulty. And part of my job was to  
3 bring the program up to accreditation. And I had to  
4 meet with the people in Mountain States on multiple  
5 occasions about citations we received from the  
6 accrediting body, the ACGME. And a lot of the  
7 citations we had were related to the service load  
8 that residents were required to carry at Woodridge.

9 And so when I was saying that sometimes things  
10 were cooperative and sometimes they weren't, those  
11 meetings were very adversarial in that I was in a  
12 situation where I needed to decrease the amount of  
13 service the residents -- and maximize the education,  
14 and there were lots of -- there was lots of  
15 disagreement about how I would do that.

16 Q. And do you know anything about the source of  
17 the funds that Mountain States receives for the  
18 graduate medical education?

19 A. Well, I do know that Medicare funds the  
20 majority of the spots, and then they supposedly pass  
21 that money on to ETSU to pay for residency spots.

22 Q. Why do you use the term "supposedly"?

23 A. A point of contention has been that Mountain  
24 States doesn't send all the money they receive from  
25 the government to ETSU, and they, I think, withhold

1 approximately 25 to 30 percent of that, as opposed to  
2 VA which sends all of the money for teaching.

3 Q. You were asked by Mr. Jackson about the child  
4 psychiatry recruitment effort. How long has it been  
5 since there was a board-certified child and adolescent  
6 psychiatrist at Woodridge?

7 A. May of 2014.

8 Q. And who was it?

9 A. That was Dr. Jill McCarley.

10 Q. And where is she now?

11 A. She's working at the VA.

12 Q. So she is board certified as a child and  
13 adolescent psychiatrist?

14 A. Yes.

15 Q. And so she would be available to be recruited,  
16 wouldn't she?

17 A. Theoretically, yes. She left to go to the VA.

18 Q. Do you know anything about the position of  
19 Strategic Behavioral Health as to similar residency  
20 funding? Have you heard anything about that or have  
21 you seen anything about that?

22 A. I haven't seen anything about that. I did  
23 have discussion, and I'm not sure who it was, about  
24 that they would be open to that and that they had  
25 partnered with other institutions in the past. I

1 think Scott and White in Texas is what I was told.

2 MR. WEST: That's all the redirect I  
3 have, Your Honor.

4 MR. JACKSON: Nothing, Your Honor. Thank  
5 you.

6 THE COURT: Thank you, Dr. Elliott. You  
7 can leave. Please don't discuss your testimony or the  
8 exhibits with anyone else that may testify in this  
9 matter.

10 THE WITNESS: Sure.

11 (Witness was excused.)

12 MR. CHRISTOFFERSEN: For what it's worth,  
13 Your Honor, if I do have a question for a witness,  
14 it's probably easier for me to just interrupt when  
15 that time comes.

16 THE COURT: I apologize I didn't --  
17 you're out of my line of vision is part of the  
18 problem, Mr. Christoffersen, sitting off to the side,  
19 but certainly don't be shy about jumping up and saying  
20 you want to question a witness.

21 And someone has come into the room,  
22 counsel.

23 MR. JACKSON: This is Dr. Collier,  
24 Dr. Deborah Kolb Collier, our expert witness, Your  
25 Honor.

1 THE COURT: Okay. Fine.

2 Are you ready to recall Mr. Shaheen?

3 MR. WEST: Well, Your Honor, Mr. Shaheen  
4 has asked for a temporary, like a five-minute or  
5 two-minute break to avail himself of the facilities.

6 THE COURT: Okay. We'll take a short  
7 break.

8 (Recess observed.)

9 DIRECT EXAMINATION (Continued)

10 BY MR. WEST:

11 Q. Mr. Shaheen, you know you're still under oath?

12 A. Yes.

13 Q. In the course of this case and in preparing  
14 for your testimony, did you have opportunity to review  
15 certain documents from Mountain States about the --  
16 they're called patient flow sheets from Woodridge  
17 Psychiatric Hospital?

18 A. Yes, I did.

19 Q. Recently?

20 A. Yes.

21 MR. WEST: And if I may, Your Honor, I  
22 would like to approach the witness and tender him the  
23 document.

24 BY MR. WEST:

25 Q. Can you look at the document, Mr. Shaheen, and

1 tell the Court whether you've seen a copy of it  
2 before?

3 A. I have. I have.

4 Q. And was it just recently, before this hearing?

5 A. Yes. Yes.

6 Q. Looking at it -- and I know it's not your  
7 document, but what does -- could you describe -- just,  
8 say, take the top sheet for -- the date given at the  
9 top is January 1 of 2015. Can you state what the  
10 sheet appears to indicate to you?

11 A. Yes.

12 MR. SWEARINGEN: Your Honor, I'm going to  
13 object to this line of questioning. As Mr. West just  
14 accurately stated, these aren't his documents. These  
15 are flow sheets prepared by Woodridge.

16 And unless he's simply going to ask him  
17 to do some math, which I think would be a little bit  
18 of a waste of time, he doesn't know how these are  
19 prepared, what they're meant to represent or how  
20 they're tabulated.

21 If Mr. West wants to question somebody  
22 about this, he can ask Mountain States how these could  
23 have come about and how they're put together, but this  
24 witness doesn't have any operational knowledge. He's  
25 never stepped foot inside Woodridge and doesn't know

1 how these were put together or what they're intended  
2 to show.

3 MR. WEST: Your Honor, I'm just going to  
4 ask him what they say, like on this January 1, 2015,  
5 what time it indicates.

6 MR. SWEARINGEN: I don't know if a  
7 reading comprehension exercise really is an  
8 appropriate use of the Court's time or, again, to give  
9 proper probative value as to what these documents are  
10 meant to represent.

11 THE COURT: Well, if it's going to be  
12 simply what they say, I think he can do that. And if  
13 anybody wants to go into any detail, you can do that  
14 on cross or with your own witnesses, if that's  
15 something you want to do, counsel.

16 BY MR. WEST:

17 Q. Date and time as indicated on this top page  
18 for January --

19 A. Is 1/1/2015 at 7:30 -- 0730, which is 7:30 in  
20 the morning.

21 Q. All right. And what MSHA document number is  
22 on the lower right corner?

23 A. 001906.

24 Q. And just in your quick survey here, looking at  
25 this large group of documents, do they all appear to

1 follow the same format?

2 A. They do. They do.

3 Q. And do they all bear the MSHA -- a MSHA  
4 document number at the lower right?

5 A. They do.

6 MR. WEST: Your Honor, at this time, I'd  
7 like to make this the next exhibit.

8 MR. SWEARINGEN: I would object, Your  
9 Honor. I don't think any foundation has been laid as  
10 to either the authenticity or what these documents  
11 are.

12 MR. WEST: Your Honor, these were  
13 documents produced in discovery by our opponents and  
14 they are marked highly confidential and they bear  
15 MSHA document numbers, and therefore we have received  
16 them in preparation -- in response to discovery.  
17 Mr. Shaheen has looked at them. We'd like to move  
18 them into evidence.

19 As you indicated earlier, if they have  
20 questions for their own witnesses for them -- we would  
21 like them placed in the record so we can address them  
22 further as we go forward.

23 MR. SWEARINGEN: Your Honor, we produced  
24 over 4,500 pages of documents in this case, and just  
25 because we produced them doesn't make them admissible

1 into evidence.

2 THE COURT: Well, they would have to have  
3 a basis in the rules, Mr. West, to be admissible, and  
4 I don't think your client can establish business  
5 records exceptions for Mountain States' records. So  
6 if you-all can't agree to it, then --

7 MR. SWEARINGEN: If he would like to ask  
8 this witness some questions about it, I don't have a  
9 problem with him marking it for identification, but as  
10 far as whether it's actually admissible into evidence  
11 to be considered as part of the record, I don't think  
12 enough has been done as of yet to do that.

13 MR. WEST: I would like to do that for  
14 that purpose, if I may, Your Honor, just to mark it  
15 for identification and to ask him a follow-up question  
16 about the date and time, for example.

17 THE COURT: All right. Well, we can go  
18 ahead and mark it for identification purposes. And  
19 tell me what the number was.

20 MR. SWEARINGEN: I don't know. This was  
21 on Mr. West's exhibit list, which I didn't --

22 MR. WEST: We could just mark it  
23 Identification Exhibit Number 1 for now, and then  
24 we'll be able to pin down --

25 THE COURT: So it's not one that is

1 premarked?

2 MR. WEST: That's correct.

3 THE COURT: All right. So we'll mark it  
4 for identification only Number 1. And they are -- I  
5 believe you called them Mountain States' flow sheets;  
6 is that correct?

7 MR. WEST: The title is Patient Flow  
8 Sheet.

9 THE COURT: Mountain States --

10 MR. WEST: They bear the logo at the  
11 bottom, MSHA document number.

12 THE COURT: -- patient sheets?

13 MR. WEST: Yes, sir.

14 THE COURT: Is there a date to reference  
15 it?

16 MR. WEST: Up at the top, the first one  
17 is 1/1/15.

18 (Marked Exhibit No. 1 for  
19 identification.)

20 THE COURT: Okay. You said you had some  
21 additional questions?

22 MR. WEST: Yes.

23 BY MR. WEST:

24 Q. Mr. Shaheen, if you will look at this  
25 document. Do all the documents, at least, and in your

1 survey sitting here today, appear to bear the time  
2 0730 in the upper right corner?

3 A. They do. Some are 0830, 0800, and 0730, 0815,  
4 but all within that time window, yes.

5 Q. And you had -- when your hospitals measure  
6 their occupancy, when do they measure it at?

7 A. Midnight. We do this exact same patient flow  
8 sheet. This is very common in our industry, to have  
9 these types of flow sheets. We do ours at midnight --  
10 or 12:01, rather, typically.

11 Q. And for Medicare purposes, in your experience  
12 as a hospital company executive or as a -- in your  
13 prior experience as a hospital CEO, when does  
14 Medicare, for example, consider a patient day to have  
15 occurred?

16 A. Anytime during that day up until midnight of  
17 that day. And so the second patient day or the next  
18 patient day would be after midnight.

19 Q. So in your experience at least at Strategic,  
20 if a patient is in a bed at midnight, then that would  
21 be another day of billing, or at least -- well, would  
22 there be another day of billing that would follow the  
23 next day?

24 A. Not if they were discharged that next day.  
25 You can only bill for the patient if they are in the

1 bed at midnight. That's the Medicare rule.

2 Q. So if they stayed past midnight but got out at  
3 8:00 a.m, could they be billed for the next day?

4 A. You would bill for the previous day, but you  
5 wouldn't bill for that day of discharge.

6 MR. WEST: Thank you. I think you can  
7 tender that to the court reporter for now.

8 Your Honor, I'm going to ask Mr. Shaheen  
9 next about a document that does have a prior  
10 identification number. Let me just be certain here.  
11 It would be Document Number 79, I believe, in this  
12 notebook. I apologize for my lack of familiarity with  
13 the notebook, Your Honor. I promise to improve.

14 Travis, it's under Tab 79, but it's  
15 marked as Exhibit 70.

16 MR. SWEARINGEN: That may have been one  
17 of the ones that got misnumbered. If you don't mind,  
18 let's just go with what's in the --

19 MR. WEST: The tab number?

20 MR. SWEARINGEN: The tab number.

21 MR. WEST: All right.

22 MR. CHRISTOFFERSEN: Is that going to  
23 lead to confusion if it had 70 on it?

24 MR. JACKSON: Our brilliant system seems  
25 to be falling apart.

1 MR. WEST: If I may say, Your Honor, this  
2 one is not --

3 THE COURT: Maybe that's why I've never  
4 done this system.

5 MR. CHRISTOFFERSEN: I'm not criticizing.  
6 I didn't prepare the notebook. You did the work.

7 MR. SWEARINGEN: Jim comes in behind  
8 and makes fun of our system.

9 What happened, Mr. Christoffersen, I  
10 think, is that at one or two depositions, the  
11 numbering got off, and so we've done our best to fix  
12 that.

13 MR. CHRISTOFFERSEN: Oh, no. I'm saying  
14 I acknowledge --

15 MR. SWEARINGEN: If you just want to  
16 draw, you can put a little dogleg on the zero and turn  
17 it into a 79.

18 BY MR. WEST:

19 Q. Mr. Shaheen, I want to show you a document  
20 that's been tabbed as Document 79. I haven't written  
21 the exhibit number on here, but that is the tab. I'd  
22 ask if you can identify that, please, sir.

23 A. Yes. This is our audit, our annual audit  
24 done by Horne, an independent CPA audit firm, for our  
25 fiscal year ending 2014. They always do -- it says

1 2014 and '13. They always do the previous year as  
2 well. And this particular audit was also done by the  
3 same -- '13 and '14 were done by the same auditing  
4 firm, Horne, LLP.

5 Q. And if you'll look on Page 2, what is the date  
6 that Horne, LLP, gives it near the signature?

7 A. Page 2? Oh, yes. May 8th, 2015.

8 Q. So this is the most recent audit available for  
9 SBH?

10 A. It is. It is.

11 Q. And as the CEO of SBH, can you -- and you can  
12 make reference to the financials in front of you if  
13 you need to -- can you inform the Court about what the  
14 size of the revenues of this company are, your company  
15 are, for either 2014 or currently?

16 A. Yes. Currently -- and Page 17 it's also  
17 noted. Our 2014 revenues were 104,579,689. That is  
18 accurate and correct from the company. In 2015, we  
19 are projecting that revenue to be 127 million this  
20 year. And halfway through the year, six months, we  
21 are on track to do exactly that.

22 THE COURT: What was the number you said,  
23 2015?

24 THE WITNESS: 127 million.

25 THE COURT: Okay. Thank you.

1 BY MR. WEST:

2 Q. And I know your company has made efforts  
3 toward the development of SBH-Kingsport by, you know,  
4 acquiring an interest in land or the option in land.

5 A. Right.

6 Q. But do you have -- does SBH, Strategic  
7 Behavioral Health, LLC, have other development  
8 projects underway?

9 A. We do.

10 Q. Where are those?

11 A. We have -- I will be opening up a 92-bed  
12 psychiatric hospital in Johnstown, Colorado, in about  
13 two months, and that project is -- those expenses have  
14 been fully paid for up to the last two payments for  
15 the construction of that facility, and then about  
16 3 million left to pay to finish that project out from  
17 a construction standpoint. So that's one.

18 The second one is Harlingen, Texas. It  
19 is a 94-bed psychiatric bed hospital that's under  
20 construction now. It has a \$15 million budget, and it  
21 has 14 million left to pay on it.

22 And the third is we broke ground three weeks  
23 ago in Green Bay, Wisconsin, and it is a \$13 million  
24 project that hasn't had any billings to it yet.

25 So a total of -- what's that -- 14 and 13 is

1 27, and 3, so a total of 30 million in projects  
2 underway.

3 Q. And if you were able to start the  
4 SBH-Kingsport project soon, what's your estimated  
5 budget for that? And you can estimate.

6 A. It's about 11 -- about 12 million. I think  
7 it's 11,717, about \$12 million.

8 Q. And on what basis do you -- or do you claim  
9 that your company is capable of developing all of  
10 these?

11 A. Yes. I have a line of credit.

12 Q. When you say "I," you mean your company?

13 A. The company has a line of credit of  
14 150 million, of which, as of June 30th, 79.9 million  
15 is drawn down on that credit facility, so that leaves  
16 -- basically, it leaves 70 million available. Plus  
17 I have an additional about 25 to 30 million in cash  
18 flows from the company to add to that, so that gives  
19 us about just under 100 million available to us to  
20 build projects. So one more \$12 million project is  
21 easily covered.

22 Q. And once the project -- you've talked some  
23 about the ramp-up period.

24 A. Yes.

25 Q. Once any new hospital such as Green Bay or

1 somewhere completes the ramp-up period, then it starts  
2 billing for patients?

3 A. It does. Well, it starts billing for patients  
4 Day 1. Well, I say Day 1. You have to go through a  
5 certification period that usually lasts about 30 days.  
6 But when we open a facility, that's all built into  
7 those numbers I just quoted you in terms of the cost  
8 to build the facility. Those losses during those time  
9 periods are all built into those numbers.

10 Q. So they're accounted for within your  
11 spreadsheet that you just spoke about?

12 A. They're accounted for within those total  
13 expenditures, yes.

14 MR. WEST: Your Honor, if I may, I'd like  
15 to make this Exhibit 79.

16 THE COURT: All right. The next exhibit  
17 will be marked Exhibit 79, and it's identified as SBH  
18 and Subsidiaries Consolidated Financial Statement for  
19 the Years Ended December 31st, 2014, and 2013.

20 And, counsel, in the copy that I have,  
21 can we avoid some confusion if the court reporter puts  
22 her exhibit sticker over the Exhibit 70, or is that a  
23 bad idea?

24 MR. SWEARINGEN: I think that's a good  
25 idea.

1 MR. WEST: That's a good idea.

2 THE COURT: Okay. Let's do that, then.

3 (Marked Exhibit No. 79.)

4 MR. WEST: Your Honor, if I may, I would  
5 like for my next -- the reason I'm taking this up now,  
6 the next exhibit I had prepared is a copy of the CON  
7 application and the relative -- there's two state  
8 reports that accompany it, and these are all drawn  
9 from the HSDA files. This is the Exhibit 9 from the  
10 Garone deposition.

11 And the issue about it -- and I want to  
12 preempt any concern -- is attached to the back of this  
13 exhibit are a number of letters of -- I see letters of  
14 support. There may be letters of opposition as well.  
15 I haven't gone back through it in detail.

16 And given the Court's prior ruling, what  
17 I propose to do is remove those letters and then just  
18 use the rest of it as the exhibit, if that's okay with  
19 opposing counsel.

20 THE COURT: Sounds reasonable to me.

21 Counsel?

22 MR. SWEARINGEN: I agree. The only thing  
23 I don't think would be in there would be the minutes,  
24 and so we can just pin them to the back tomorrow  
25 morning. I can bring copies of that.

1 MR. WEST: I would also say, Your Honor,  
2 subject -- I assume that -- it looks to me to be a  
3 complete set of the reports and the CON application.  
4 And so I believe -- I do want to compare it to  
5 Mr. Christoffersen's file copy of the CON and just  
6 make sure it's consistent, but I think it is. I  
7 believe it to be.

8 MR. CHRISTOFFERSEN: That's my  
9 understanding, Your Honor.

10 MR. SWEARINGEN: I have no reason to  
11 believe that there's anything missing, again, except  
12 for the minutes.

13 THE COURT: And so tomorrow you-all will  
14 supplement -- you'll have a copy of the minutes and  
15 we'll put it with the exhibit?

16 MR. SWEARINGEN: Yes.

17 THE COURT: All right.

18 MR. CHRISTOFFERSEN: Now, Mr. West, just  
19 so I'm clear, and I think you already said this, the  
20 two copies of the reviewing agency report, they're the  
21 ones from the Agency's file, correct, as opposed to  
22 anything you went and got from the reviewing agency  
23 itself?

24 MR. WEST: I believe that's correct.

25 MR. CHRISTOFFERSEN: Okay.

1 MR. WEST: That appears to me to be  
2 correct. Let me double-check.

3 MR. CHRISTOFFERSEN: I just want to make  
4 sure we're all reading off the same page.

5 MR. WEST: Yes. Because there was a  
6 distinctive report from one of the agencies that had  
7 three versions. This is the final version.

8 Your Honor, if could I take a moment just  
9 to separate these.

10 THE COURT: That's fine.

11 You can look in your copy of your  
12 notebook, Mr. Christoffersen, to see if it's what you  
13 expect it to be.

14 MR. CHRISTOFFERSEN: Thankfully, in these  
15 cases, that's usually the least of things the parties  
16 may disagree about, but when it comes to reviewing  
17 agency report, there may be different copies floating  
18 around.

19 MR. WEST: Your Honor, could we go off  
20 the record just a second?

21 THE COURT: Certainly.

22 (Discussion off the record.)

23 BY MR. WEST:

24 Q. Mr. Shaheen, I'm going to hand you a document  
25 that was marked Exhibit 9 in Mr. Garone's deposition

1 -- it doesn't have an exhibit number on it yet -- and  
2 ask if you can identify that, please, sir.

3 A. I can. This is the Health Services and  
4 Development Agency application summary, as well as  
5 it looks like our application that we turned in  
6 requesting the Certificate of Need. That's what it  
7 is.

8 Q. If there are some scattered letters in there,  
9 just ignore those.

10 A. Yeah. What I was looking for -- I don't know  
11 if the Department of Mental Health's report is in  
12 here.

13 Q. Is it? Let me ask you.

14 A. Yes. From Sandra Braber-Grove to Melanie  
15 Hill. So this is the second amended report from the  
16 Department of Mental Health.

17 Q. All right. Let me ask you -- again, I may be  
18 repeating a question here, but did you participate in  
19 the development of this CON application?

20 A. I did.

21 Q. And what was your relationship to Mr. Garone's  
22 -- well, first of all, let me ask you this: What is  
23 Mr. Mike Garone's position with your company?

24 A. He's the director of development. He is  
25 charged with helping the company decide where it wants

1 to build new facilities, and he's charged with helping  
2 facilitate that process, whether it's a Certificate of  
3 Need or not. Some states are and some states are not.

4 His role is to do the groundwork around  
5 each community, introduce us as a company to those  
6 communities, receive feedback from those communities,  
7 and in turn in a situation where it's a Certificate of  
8 Need. He's charged with putting the first -- putting  
9 the Certificate of Need together based on the  
10 questions that the Certificate of Need application  
11 asks you to answer, and he's charged with doing the  
12 physical work around putting all of that together.

13 Q. Did he also play a role in identifying a site  
14 for the project?

15 A. He did, yes. And he's charged with  
16 identifying -- both engaging a real estate agent as  
17 well as looking at sites and narrowing them down to an  
18 acceptable few sites, several sites. We actually pick  
19 multiple sites, and then my role is to come in behind  
20 and determine which ones are viable for our project.

21 Q. If you'll look on the very first page of this  
22 document in front of you, it gives an address for this  
23 proposed SBH-Kingsport, LLC.

24 A. Yes.

25 Q. Can you explain why you picked that project --

1 that location?

2 A. Well, the particular piece of property that we  
3 found, again, with limited knowledge of sort of the  
4 layout of the city, seemed to be in the middle of lots  
5 of businesses going on, so it seemed to be appropriate  
6 for this type of business to be there.

7 And, in fact, we saw health care companies'  
8 logos in different areas, meaning physicians' offices  
9 and those kinds of things. So to me it felt like a  
10 medical park or a medical type area. So that's part  
11 of why I determined this was an appropriate place to  
12 put the actual facility.

13 In addition to that, certainly the zoning was  
14 zoned appropriate. That's important for us. And the  
15 price of the land also was an important component of  
16 that decision.

17 Q. Are there any buildings on the land now?

18 A. No, not on the land.

19 Q. If you'll look at the bottom of the first  
20 page, I think it specifies the bed breakdown. Could  
21 you reiterate that for the record, please?

22 A. Yes. The proposed mental health hospital  
23 consists of 28 inpatient beds for psychiatric care of  
24 children ages -- consists of 28 inpatient psychiatric  
25 care for children ages 5 to 17; 18 inpatient beds for

1 adult psychiatric care of adults ages 18 to 64; 16  
2 inpatient beds for geropsychiatric care for ages  
3 55-plus; and 10 adult chemical dependency beds for  
4 adults.

5 Q. And what is the total project cost listed on  
6 this page?

7 A. \$11,717,915.

8 Q. You have spoken about, and I think we actually  
9 heard some testimony from Dr. Elliott -- about  
10 geropsychiatric patients.

11 A. Yes.

12 Q. I notice that in the age breakdown, the  
13 geropsychiatric age breakdown overlaps some with the  
14 adult breakdown.

15 A. Yes.

16 Q. Can you explain why that is?

17 A. Sure. A geriatric psychiatric program focuses  
18 more clinically on both the medically-compromised  
19 patient as well as the diminished capacity of a  
20 geriatric population to do things like physical  
21 exercise or different clinical interventions that we  
22 might use.

23 The reason it goes to 55 and above is because  
24 there are, many times, 56-, 58-, 60-year-olds that  
25 cannot participate in the types of interventions that

1 a more healthy adult might and it's more appropriate  
2 for them to be both clinically programmed and  
3 participate in a program that's specifically designed  
4 for that type -- those types of limitations for  
5 patients, and so that's where the overlap is.

6 It's not a hard-and-fast rule. It is  
7 clinically appropriate for -- determined by the  
8 physician and by the clinician where it's clinically  
9 appropriate for that patient to be, whether it's a  
10 geriatric psychiatric unit or a regular adult unit,  
11 and vice versa. On the adult side, there are  
12 60-year-olds that can be on our adult unit because  
13 they are -- they can participate in all of that  
14 program's clinical interventions, or the majority,  
15 let's say.

16 Q. In your geropsychiatric units that SBH runs at  
17 its various hospitals, could you describe the payor  
18 breakdown for those units, typically?

19 A. What typically happens in a geriatric  
20 psychiatric, because they are the elderly population,  
21 the majority -- in my experience for the last  
22 27 years, the majority in those programs are under  
23 Medicare because the majority are age 64 and above  
24 when you become eligible for Medicare, and Medicare  
25 becomes the primary payor.

1           So, you know, off the top of my head, it's  
2 usually 85, 90, 95 percent of the entire geriatric  
3 population is Medicare. That just somehow tends to  
4 play out in all of my hospitals in all of my geriatric  
5 programs.

6 Q.       If an individual is over 55 and was a  
7 recipient of Social Security Disability --

8 A.       Uh-huh.

9 Q.       -- would he or she have Medicare coverage?

10 A.       They would. They would. The disability  
11 allows them to be eligible for Medicare, and they  
12 might be dually eligible for Medicaid as well, as a  
13 secondary payor, but they would be eligible.

14           And so we do have -- on the adult unit, as an  
15 example, we would have Medicare patients there for  
16 that particular population, or that population, in  
17 terms of its disability, might be severe enough that  
18 they might be, again, on the geriatric unit. It may  
19 not be a 64-and-above Medicare issue, it might be an  
20 age 58 Medicare issue, but clinically they need to be  
21 on the geriatric unit.

22           So, again, that's part of what's driving that  
23 Medicare number so high on that particular program  
24 as well, because the disability itself, clinically,  
25 actually makes them appropriate for that kind of

1 program, typically.

2 Q. And in setting forth and deciding the bed  
3 breakdown for this project in Kingsport, did you  
4 consider those payor sources as you've just discussed?

5 A. Yes. Yes.

6 MR. WEST: Your Honor, I apologize.  
7 We've been through so many versions of this document,  
8 but my annotated version for personal use has been  
9 misplaced somewhere.

10 BY MR. WEST:

11 Q. Mr. Shaheen, you'll notice -- and I ask  
12 you to ignore any letters you see in this particular  
13 document, but if you look, this document is paginated  
14 at the top with what we call Bates numbers. You'll  
15 see they're in sequence. Do you see that?

16 A. Okay. I do. The typewritten numbers?

17 Q. Yeah, in the middle of the top of the page.

18 A. Yes, I see that.

19 Q. If you would turn to Page 61.

20 A. Okay.

21 Q. And can you describe what this document  
22 portrays?

23 A. This is the building that we are proposing and  
24 had proposed to build. These -- it's labeled which  
25 units would be for which populations here. This is

1 the -- this is one of the several designs that we  
2 have.

3 Q. And this document appears to show a central  
4 courtyard. Is that the courtyard you were referring  
5 to earlier?

6 A. It does. When I was referring to that  
7 earlier, that's the center courtyard that is  
8 surrounded by the building that allows patients to get  
9 outside and still be in a secure setting.

10 Q. If you sort of go counterclockwise from the  
11 geriatric unit, it appears that there's -- to me,  
12 anyway -- and let me ask you if this is correct. It  
13 says geriatric unit, paralleled by an adult unit that  
14 right angles to an adolescent unit, and then there's a  
15 child unit and then a chemical dependency unit. Does  
16 that go around the horn, so to speak?

17 A. That is correct. That is absolutely correct.

18 Q. And I note there's a comment on here that all  
19 patient bedrooms are semi-private.

20 A. They are.

21 Q. In your other facilities, are they  
22 semi-private or private, or what is the mix?

23 A. In every single one of my hospitals, they are  
24 all semi-private rooms.

25 Q. And why do you use semi-private rooms?

1 A. Well, there's any number of reasons. One is  
2 these psychiatric patients -- as I mentioned earlier  
3 in my testimony, these patients have tried to harm  
4 themselves, and clinically it's actually safer to have  
5 a roommate with these patients.

6 Again, staff are there to keep an eye on them  
7 at all times, but it's always great to have patients  
8 that are not isolated and not -- there are times you  
9 have to isolate patients for seclusion, for restraint  
10 or for a medical emergency, but as an overall  
11 philosophy, we believe very strongly that the -- we  
12 call the group the milieu, that is the atmosphere, if  
13 you will. The unit with which they are participating  
14 in care is called the milieu. And so it's always good  
15 to have patients within the milieu of the same type,  
16 of the same -- that's why we separate them as well.

17 Q. And milieu is spelled M-I-L-I-E-U; is that  
18 right?

19 A. I think you spelled that right, yes. It's a  
20 funny looking word.

21 Q. Displaying my knowledge of French there.

22 If you'll look at Page 131, the area marked  
23 Supplemental Number 2.

24 A. Uh-huh.

25 Q. I notice that on Page 131 -- that's the

1 Bates-numbered page -- there's a comment that  
2 "Strategic Behavioral Health currently operates a  
3 total of 387 child and adolescent inpatient beds in  
4 four states: North Carolina, Colorado, New Mexico,  
5 and Nevada." Is that still an accurate number, the  
6 number of child and adolescent beds that y'all have?

7 A. It's not, because we have, since then, since  
8 this was filled out, opened up a 20-bed child and  
9 adolescent unit in College Station, Texas. We opened  
10 up a 72-bed psychiatric hospital in College Station,  
11 Texas, and of that, 20 of those beds are dedicated to  
12 child and adolescent in that particular facility. So  
13 that would be added to that number.

14 Q. So over 400 now, child and adolescent beds?

15 A. Yes. Yes. And the rest of these numbers are  
16 the same. From this application, that hasn't changed.  
17 We haven't closed any or shifted any or anything like  
18 that.

19 Q. And I apologize for skipping around like this,  
20 but this is an unannotated version here. If you look  
21 at Page 46, I wanted to ask you about funding sources.  
22 Do you see there the funding sources listed as cash  
23 reserves and other? How does that relate to your  
24 description of the current financial structure and  
25 bank loan arrangements that Strategic has?

1 A. Well, from the time that we filed this, it has  
2 been -- just continually been enhanced and improved  
3 upon to the amount that I just expressed earlier,  
4 having just under 100 million available, between 30  
5 million -- or 25 to 30 million in operating cash flows  
6 from the company in addition to a line of credit. Our  
7 line  
8 of credit, since this has been filed, has been -- was  
9 increased in December of this last year to 150 million  
10 from what it was previously.

11 Q. And who is the CFO of Strategic Behavior?

12 A. James Cagle is my current CFO.

13 Q. And he's given a deposition in this matter,  
14 hasn't he?

15 A. He has. He has.

16 Q. Now, I'm sort of working my way backwards, it  
17 appears, through the document. If you look at Page 7,  
18 the staff summary?

19 A. Uh-huh.

20 Q. In this, the staff summary, the staff appears  
21 to address a concept known as the institute for  
22 mental disease under Medicaid. Can you describe your  
23 understanding of what an IMD is and how that affects  
24 your project?

25 A. Yes. An institute for mental disease was

1 created by the federal government in the '60s for the  
2 purpose of deinstitutionalizing the state asylums,  
3 they used to call them. And one of the ways they  
4 did that was to file a -- basically say that federal  
5 money, Medicaid dollars, could not fund; that they  
6 were basically freestanding psychiatric hospitals or  
7 psychiatric care. They termed them institutes for  
8 mental disease back then.

9 Then in the late '70s, early '80s the  
10 federal government came back and said only for 21-  
11 to 64-year-olds. At 21 and below, meaning child and  
12 adolescent, and up to 21 could actually -- they could  
13 fund for psychiatric patients in a freestanding  
14 psychiatric hospital.

15 Q. You mean through Medicaid?

16 A. Through Medicaid, correct. Each state gets  
17 a federal match for their Medicaid dollars. And so  
18 in the state of Tennessee, as an example, a patient  
19 that is age 21 to 64, if they go to a freestanding  
20 psychiatric hospital, the state is not allowed to draw  
21 down the federal matching funds. And in Tennessee, I  
22 think it's 67 percent of the federal matching funds,  
23 for those Medicaid dollars. They are required to  
24 pay 100 percent of that to the institute for mental  
25 disease that they are purchasing beds for, for, again,

1 that population 21 to 64.

2 Q. When you said "they," you mean --

3 A. The state. The Medicaid -- the Bureau of  
4 Medicaid. Every state sort of names them differently.  
5 The Bureau of Medicaid is TennCare in Tennessee.

6 Q. Well, wouldn't that have a negative impact on  
7 Strategic Behavioral Health-Kingsport's capability in  
8 serving these patients?

9 A. Well, it limits the population with which you  
10 would be allowed to treat, yes, because those patients  
11 are not allowed to be in a freestanding hospital for  
12 reimbursement. They are required to be in a non-IMD,  
13 a medical/surgical system or a facility that is a  
14 satellite of a medical/surgical system.

15 Q. And have you had any contacts with the state  
16 Medicaid office about this issue?

17 A. We have. We have. Because we do this  
18 nationally, every state truly manages their Medicaid  
19 a little differently. Some states absolutely will  
20 refuse to pay for 21 to 64 in a freestanding  
21 psychiatric hospital because they do not want to foot  
22 the federal match bill with 100 percent state dollars.

23 In other states, like Tennessee, they actually  
24 have made the choice that they do want to fund -- they  
25 see the value in a freestanding psychiatric hospital,

1 and they are using 100 percent state dollars; they're  
2 not using the federal matching dollars. But they've  
3 made a choice in Tennessee to allow that. And that  
4 occurs around the state as an option for the TennCare  
5 providers to contract with freestanding psychiatric  
6 hospitals.

7 Q. But, in general, as you look at the range of  
8 ages here on Page 1 of the application, TennCare  
9 eligibles up to age 21 can be paid for by Medicaid or  
10 TennCare?

11 A. Correct.

12 Q. And 55 and over, especially 65 and over, that  
13 would be primarily Medicare; is that right?

14 A. Correct.

15 Q. So the people in the middle, if they're  
16 TennCare eligible, they could be covered, possibly, if  
17 the state follows that line that you just spoke of,  
18 right? Is that correct?

19 A. Yes, that is correct.

20 Q. And is there commercial insurance available  
21 for psychiatric care?

22 A. There is. In fact, part of what has produced  
23 and is -- part of what is driving the need around the  
24 country, as we see it as a national company, is not  
25 only the ACA enrolling uninsured folks that are

1 required to provide mental health and substance abuse  
2 services where here, before, we were not required --  
3 insurance companies nor the ACA didn't exist, but in  
4 addition to that, existing insurance companies as of  
5 July of 2014 were required to provide mental health  
6 and substance abuse inpatient services as a benefit  
7 and could not exclude that anymore. And so we've  
8 spent years of those commercial patients actually  
9 being excluded from that benefit for inpatient  
10 psychiatric and substance abuse care.

11 Q. What impact has Strategic Behavioral Health,  
12 LLC, observed of the 2014 change with regard to  
13 insurance companies and coverage of alcohol and  
14 chemical dependency and mental health?

15 A. Interestingly, we are just now starting to see  
16 that change, and the reason for that is July 2014 was  
17 when it was required to begin by the federal parity  
18 act, and the rules spell that out. But what it also  
19 says is that the insurance companies had to be in  
20 compliance by July of 2014 or when they renewed their  
21 insurances.

22 And the majority of the insurances have a  
23 calendar year. So January of '15 we have started to  
24 see significant increases of folks that have access  
25 to mental health and substance abuse care because of

1 those changes, because those commercial policies are  
2 now required -- if they renewed in January, would then  
3 be required by January 1 of '15 to begin to cover  
4 those services, where here, before, they did not.

5 MR. WEST: Your Honor, if I may, I'd like  
6 to make this document Exhibit 9.

7 MR. SWEARINGEN: No objections subject to  
8 all of our previous discussions.

9 MR. WEST: Yeah. That's true.

10 THE COURT: And just to be clear what it  
11 contains, now that the witness has testified about it,  
12 it's the CON application for the SBH-Kingsport as well  
13 as the Agency staff summary and the Department of  
14 Mental Health's report. Those are the documents  
15 contained in Exhibit 9. And tomorrow you're going to  
16 supplement the minutes.

17 (Marked Exhibit No. 9.)

18 MR. WEST: Yeah. And to the extent it  
19 contains letters, we will extract them.

20 BY MR. WEST:

21 Q. Mr. Shaheen, you've testified this afternoon  
22 about payor sources for mental health and substance  
23 abuse services.

24 A. Right.

25 Q. And you listed Medicare, commercial -- you

1 were asked about Medicare, commercial insurance and  
2 Medicaid or TennCare. What other sources in Tennessee  
3 are there of reimbursement to hospitals for  
4 psychiatric care?

5 A. The state Department of Mental Health provides  
6 reimbursement for patients that would have otherwise  
7 been in the state hospital. They contract locally --  
8 typically, locally with providers to provide that  
9 care in replacement for them being at the state  
10 hospital. They provide funding for those patients.

11 Q. And you're aware that the state hospital in  
12 Knoxville no longer operates; is that correct?

13 A. Correct.

14 Q. And in your understanding what did the state  
15 do -- when I say the "state," I mean the Department of  
16 Mental Health -- do in order to sort of fill the gap  
17 after Lakeshore closed?

18 A. Basically, the back story is that state  
19 psychiatric hospitals are expensive, if you will. And  
20 those dollars that they expend on a state psychiatric  
21 hospital can be redirected when the psychiatric  
22 hospital closes and can use those same dollars to pay  
23 for the same services that the state hospital was  
24 providing, assuming the providers are willing to  
25 accept those types of patients.

1 Q. And at Strategic Behavioral Health, do you  
2 have the power to execute contracts on behalf of the  
3 company?

4 A. Absolutely I do.

5 Q. What is your attitude -- or what would you  
6 do if you had the opportunity to sign one of these  
7 contracts for psychiatric hospital services between  
8 one of your hospitals in Tennessee and the Tennessee  
9 Department of Mental Health and Substance Abuse  
10 Services?

11 A. We would love to do that. We think it's --  
12 again, as I understand the funding stream and what  
13 it's identified for, it's identified for patients that  
14 would have otherwise been underinsured or uninsured,  
15 what folks term as an indigent patient. But once they  
16 become a payor source, they're no longer indigent.  
17 You actually get funding directly from the state for  
18 that.

19 And so we would absolutely love to have a  
20 contract like that because -- and in our application,  
21 you can see, we were willing to take all folks,  
22 including indigent. So to get that funding stream  
23 would be in addition to what we were already planning  
24 on doing, so that will be just fine.

25 Q. Do you know offhand what your projected level

1 of charity or indigent care is proposed to be for  
2 SBH-Kingsport, LLC?

3 A. In this project, it's 5 percent.

4 Q. And what about at your other hospitals? Say,  
5 in North Carolina, what is the level of indigent care  
6 there?

7 A. Well, it's significantly lower because of  
8 what I described earlier in my testimony; that it's  
9 strictly child and adolescent and those folks are  
10 eligible for Medicaid as well as the same description.  
11 The Department of Mental Health subcontracts the MCOs  
12 to pay for those patients without -- underinsured or  
13 uninsured for services in North Carolina.

14 And so we do not register them -- even though  
15 their eligibility criteria is the word "indigent,"  
16 they don't get registered in our system as an indigent  
17 patient. If there's any payor source that is attached  
18 to them, whether it's state funding, they do not get  
19 registered as indigent patients.

20 So the indigent patients we're talking about  
21 in this application are truly zero dollars being  
22 reimbursed for that population. When we use the term  
23 "indigent," there are zero dollars for those patients.

24 Q. What about your other facilities? When I say  
25 "your," I mean Strategic Behavioral Health's other

1 facilities in other states that don't have the North  
2 Carolina Medicaid program?

3 A. They vary, but in Nevada, as an example, I  
4 think we're running probably 7 percent indigent,  
5 somewhere around there. And, again, don't quote me  
6 on that, but I'm just -- because the system is  
7 designed -- there are some states that have closed  
8 state psychiatric hospitals and my indigent might be  
9 higher versus states that actually have operating  
10 psychiatric hospitals that the states ask us not to  
11 admit those patients and to, in fact, refer them to  
12 the state hospital because that's the designated place  
13 with which those patients are supposed to go because  
14 they are identified as either a former patient of the  
15 state hospital system or identified as the -- where  
16 the dollars are coming down to pay for those clients  
17 within the state hospital system. And so it varies.

18 In College Station, Texas, right now we're  
19 probably running about 10 percent indigent. In New  
20 Mexico -- New Mexico would be a lower number because  
21 there's a higher number of child and adolescent beds  
22 there. So, again, it really sort of varies across the  
23 company, but I think the company average -- I think we  
24 answered it in one of our interrogatories -- it was  
25 north of 5 percent.

1 Q. Mr. Shaheen, prior to the HSDA vote on this  
2 SBH-Kingsport, LLC, application on June 25 of 2015,  
3 prior to that, did you personally have any contacts  
4 or meetings with any personnel from Mountain States  
5 Health Alliance about East Tennessee or projects in  
6 that area?

7 A. I did. I did. I received a call from  
8 Mr. Nicely who was, at the time, the CEO, I think, of  
9 Johnson City Medical Center.

10 Q. Nicely?

11 A. I'm pretty sure that's his name. He, at the  
12 time, was the CEO. And I flew to Johnson City and  
13 sat down and met with he and, I believe, his chief  
14 financial officer, maybe Hilton, if I -- I'm not sure  
15 if I got the names right. And I sat down with them  
16 to discuss our Certificate of Need, to ask them not  
17 to object; that we would like to be a collaborative  
18 partner in this community, and asked them both not  
19 to object and to gauge their interest in selling  
20 Woodridge Psychiatric Hospital to me.

21 Q. Several more questions. If you were able  
22 to -- if Strategic was able to buy Woodridge, that  
23 ends your pursuit of SBH-Kingsport, LLC?

24 A. Absolutely not. And I told Mr. Nicely  
25 that, that we think the need is so significant in

1 this region that there needs to be an additional  
2 psychiatric hospital and that we would be more than  
3 happy to own both of those; if Mountain States were  
4 willing to sell the Woodridge facility, that it would  
5 not change.

6 And I was very clear about that, because we --  
7 the hearing had not occurred yet, so I wanted to be  
8 very honest and upfront with him to say either way, we  
9 believe that this facility is needed in the service  
10 area and we need -- we're moving forward with that  
11 regardless of your response, so that I wasn't  
12 implying, you know, if you sold me that, I wouldn't --  
13 I was very clear about that, in making sure he  
14 understood that.

15 Q. And what was Mr. Nicely's response to your  
16 statements?

17 A. He said they were in the middle of a strategic  
18 planning session and that they were getting --  
19 Mountain States was getting a new CEO for the entire  
20 system and that he had interest in potentially talking  
21 with us about selling Woodridge but that he needed to  
22 bring that to the Mountain States' strategic planning  
23 group. They were doing their, I think, five-year  
24 strategic plan, is what he was telling me. And so  
25 that was the extent of the conversation.

1 Q. And did you have any more contacts with  
2 Mr. Nicely after that?

3 A. I did not, actually.

4 Q. I don't think I've asked you this question  
5 quite this way yet. Do you believe that the  
6 SBH-Kingsport, LLC, application is needed?

7 A. Absolutely.

8 Q. And why?

9 A. As we did our national study and were studying  
10 the number of beds per 100,000 -- when you look at our  
11 service area, there's an 81-bed need. We're asking  
12 for 72 beds.

13 The reason 30 beds per 100,000 -- there's two  
14 issues around that. One is, the State of Tennessee,  
15 in its Certificate of Need, uses that formula, 30 beds  
16 per 100,000. The reality of actual care around the  
17 country is it's 50 beds per 100,000 is the standard,  
18 and that is evidenced by the national treatment  
19 advocacy groups and the National Association of  
20 Psychiatric Health Care Systems and others use 50 beds  
21 per 100,000.

22 But as a company, from a business model  
23 perspective, I wanted to be more conservative. So  
24 when we did our national study, we used 30 beds per  
25 100,000. It happened to match up with exactly the

1 formula that Tennessee uses. But we still believe  
2 that that's a very conservative number based on  
3 utilization around the country when we see that. And  
4 so that, coupled with -- again, that national study we  
5 did was strictly used to identify potential markets.

6 The real work, then, was going to the  
7 community, which Mr. Garone did and I did as well,  
8 and sit down with legitimate stakeholders within that  
9 marketplace to question and ask: Is there a need for  
10 these types of services? And if so, why is there a  
11 need? And they were overwhelming that there was a  
12 need for these populations that we've identified.

13 Q. And do you believe that the project is  
14 economically feasible?

15 A. We do. We do. We very much believe that it's  
16 economically feasible because of the way in which we  
17 have designed our buildings. I'll give you just a  
18 quick example of having designed these buildings and  
19 having owned my plans, if you built a typical hospital  
20 like this, you might spend 600- to \$800,000 in  
21 architect fees. Mine run 200-, 250,000.

22 So things like that, we save tremendous  
23 dollars, and so the price of actually -- capital  
24 needed to build these is significantly lower for us  
25 than, say, my competitors because they haven't done

1 those types of things. So that's made it economically  
2 feasible.

3 The second thing that makes it economically  
4 feasible is that when you study all of the different  
5 patient populations and understand the reimbursement  
6 rates for them and you study, like we did, the cost  
7 to provide those services, meaning what you are going  
8 to have to pay staff at all levels in that particular  
9 market versus the reimbursement, shows that it is  
10 economically feasible to do that. And our pro forma  
11 bears that out when we use the local wage scale within  
12 our pro forma and the local typical reimbursement.

13 Q. And, again, how will the construction costs  
14 and the cost of development be borne, be carried out  
15 or experienced? How will it be financed?

16 A. Through cash flows of the operations, of the  
17 existing operations, and through our \$150 million line  
18 of credit.

19 Q. And the next question is: Do you believe  
20 that this project will contribute to the orderly  
21 development of health care as required by the CON  
22 statutes of Tennessee?

23 A. I do. And I hesitate to say we probably  
24 didn't do as good a job as we should have in  
25 describing that in our process of requesting this

1 Certificate of Need, because we believe that orderly  
2 development of health care in a region is influenced  
3 by how providers behave in those areas.

4           And we didn't do a good job of explaining how  
5 we integrate ourselves into the community by sharing  
6 our physicians, as an example. We recruit physicians  
7 to the market. We share them and ask them to hang  
8 their shingle in the community and do outpatient care.  
9 We share our therapists with the community.

10           We meet with the local community providers  
11 and literally hand-deliver, as an example, discharge  
12 information before the patient gets to their  
13 appointment. We do things above and beyond so that  
14 the orderly development is enhanced.

15           The patients are allowed to go to partial  
16 hospitalization and intensive outpatient as part of  
17 the continuum of care. You have inpatient, partial,  
18 intensive outpatient, and then regular outpatient.  
19 That's your continuum of care.

20           By offering partial hospitalization  
21 and intensive outpatient and inpatient, we are  
22 contributing to the orderly development by allowing  
23 those levels of service -- by allowing patients to  
24 access those levels of service at any point. There's  
25 no requirement for one or the other. And that, in

1 addition, I think allows the orderly development of  
2 health care in the region.

3           The third thing we do is we use clinical  
4 mobile assessment I was talking about earlier. We  
5 believe that the clinical mobile assessment provides  
6 for orderly development because it gives the community  
7 additional clinical resources with which to find out  
8 where a patient needs to go and what services they  
9 might need within the community. And so we spend a  
10 tremendous amount of time working with all providers  
11 and studying and understanding their admission  
12 criteria, what payors they do and don't take.

13           And we believe that that's the definition of  
14 orderly development, in being able to work with those  
15 providers to understand what -- because I mentioned  
16 earlier, 70 percent of those patients are not coming  
17 to me; 70 percent of those patients are going into the  
18 community services that are being offered.

19 Q.           Do any of your hospitals have relationships  
20 with medical schools?

21 A.           We do. We have, for example, in Nevada,  
22 medical students and medical residents do their  
23 rotations in our hospital. Montevista, as an example,  
24 is the name of the hospital in Las Vegas. It's a  
25 162-bed hospital. It does children, adolescents,

1 adults, seniors. It does long-term residential. It  
2 does all of those services, so that's an example.

3 Q. And what are your plans, if any, for contacts  
4 with medical education in Kingsport?

5 A. Well, we -- during our due diligence process,  
6 we actually -- I think Mr. Garone sat down with  
7 Mr. Elliott, who you just heard from, who, at the  
8 time, was responsible -- the program director for  
9 that residency program, and we additionally offered  
10 to have a residency program within our hospital as  
11 well, because, again, it takes dollars to fund those  
12 residencies, and we have those. It takes, certainly,  
13 a patient flow with these residents to get experience.  
14 And thirdly, it takes, like he mentioned, as an  
15 example, a child and adolescent board-certified in  
16 order to be eligible.

17 And in our plans, we would be recruiting  
18 more than one board-certified child and adolescent  
19 psychiatrist, and we have the ability to do that as a  
20 national company. I have them in my hospitals that  
21 provide care today.

22 Q. You say that you have the capability. What  
23 steps or mechanisms does SBH, Strategic Behavioral  
24 Health, LLC, use to do such recruiting?

25 A. Several steps. One is, I think today I

1 probably have 75 to 80 psychiatrists that work in all  
2 of my hospitals, and so I start with them. Are any of  
3 them interested in relocating to a new project for us?  
4 So that's one way in which we do it.

5 The second way in which we do it is we have --  
6 I have a national firm called Compass Health Systems.  
7 They are out of Miami. And they currently employ 60  
8 to 80 psychiatrists around the country, and I contract  
9 with them to help recruit, for me, psychiatrists.

10 In some cases, they have -- those employed  
11 psychiatrists by Compass, they contract in my  
12 hospitals and provide services in my open medical  
13 staff model, so I utilize them.

14 Thirdly, we meet with -- have relationships  
15 with medical schools around the country, especially in  
16 the markets that we're currently in.

17 And, fourthly, we actually have used national  
18 search firms as well. So we have a number of  
19 resources available to us to recruit.

20 The bigger advantage here, why we're able to  
21 recruit psychiatrists, as an example, to a community  
22 that has struggled in doing that is because I have the  
23 ability, as an inpatient psychiatric hospital, because  
24 I have the revenue enough to recruit those folks. If  
25 I were just hanging a shingle and being a community

1 mental health center or outpatient provider, there  
2 isn't enough revenue with that to make an attractive  
3 offer to a psychiatrist.

4 We do practice guarantees. We do things that  
5 take significant, you know, amounts of money to do.  
6 But because it's a hospital revenue system, it allows  
7 us to do that, and that's really where the advantage  
8 is.

9 For a doc to move to a community and hang his  
10 shingle and see a patient hour after hour after hour,  
11 that takes, in some cases, a year or two years to get  
12 up to where he's even covering his expenses and that  
13 sort of thing.

14 Day 1 with us, because it's a hospital  
15 setting, I have a ready-mix of patients with which  
16 to hand to that new physician to that community, and  
17 therefore they're able to make a living much faster  
18 when they move to a new community, and we use that as  
19 a recruitment tool.

20 MR. WEST: Your Honor, I believe that's  
21 all the questions I have at this time of Mr. Shaheen.

22 THE COURT: We'll take a short break and  
23 come back and have cross-examination.

24 (Recess observed.)

25 THE COURT: You may proceed.

CROSS-EXAMINATION

1  
2 BY MR. SWEARINGEN:

3 Q. Good afternoon, Mr. Shaheen. My name's Travis  
4 Swearingen. We met back in May when I came down to  
5 Memphis to take your deposition. I'm one of the  
6 lawyers for Mountain States.

7 I wanted to follow up on a few questions that  
8 Mr. West had for you on your direct, and I thought  
9 we'd start where you-all sort of left off, which is  
10 talking about your charity care policies. Do you  
11 remember those questions that Mr. West asked you  
12 about?

13 A. Sure.

14 Q. And I'll pass forward to you what has been  
15 marked as Exhibit 7, which is --

16 MR. SWEARINGEN: May I approach, Your  
17 Honor?

18 THE COURT: Yes.

19 BY MR. SWEARINGEN:

20 Q. -- a copy of your company's interrogatory  
21 responses in this case. And you recognize that  
22 document, correct?

23 A. I do.

24 Q. And although it's signed by Mr. Garone, who  
25 we'll hear from later, you reviewed these in their

1 preparation and you signed off on them, as well, as  
2 being true and accurate statements by your company in  
3 response to the questions that we asked, correct?

4 A. I did.

5 MR. SWEARINGEN: I'd ask that this be  
6 marked as Exhibit 7, Your Honor.

7 THE COURT: Exhibit 7 will be marked  
8 SBH-Kingsport's responses to Mountain States' first  
9 set of interrogatories.

10 (Marked Exhibit No. 7.)

11 BY MR. SWEARINGEN:

12 Q. And, Mr. Shaheen, I believe when you were  
13 asked about this line of questioning by Mr. West, you  
14 testified that across the board SBH averages north of  
15 5 percent in its charity care; is that correct?

16 A. Correct.

17 Q. And we actually asked you that question in  
18 your interrogatories, for you to identify across the  
19 board, historically, what SBH facilities have offered  
20 as it relates to charity care, correct?

21 A. Uh-huh.

22 Q. And if you'll turn to Page 27 of your  
23 responses, it was Question Number 34.

24 A. Correct.

25 Q. And it says there that 19 and a half percent

1 are Medicaid across all your facilities, 29.3 percent  
2 are Medicare, 7 percent commercial, 38.6 percent  
3 HMO/PPO, 1.2 percent self-pay, and then 4.5 percent  
4 uncompensated. Do you see that?

5 A. Correct.

6 Q. And that was true and correct when you had  
7 this response prepared and filled out these responses,  
8 correct?

9 A. Correct.

10 Q. And you've put down a definition here. It  
11 doesn't actually say charity care, correct?

12 A. Right. Correct.

13 Q. And even though that was the question that we  
14 asked, charity care, indigent care, please list that  
15 out, you listed it out as uncompensated care, and you  
16 included a parenthetical there that suggests that this  
17 4.5 percent includes bad debt, denials, and  
18 administrative adjustments. Do you see that?

19 A. Correct.

20 Q. So a denial, for instance, would be when  
21 someone comes in with commercial insurance or a state  
22 reimbursement and for whatever reason, either they  
23 stay too long or for whatever reason, they're actually  
24 denied reimbursement for that, correct?

25 A. Correct.

1 Q. So this isn't a patient who shows up at your  
2 doorstep who simply has no manner of paying or can't  
3 be reimbursed, true?

4 A. It includes those, yes.

5 Q. Okay. But it includes other categories of  
6 individuals as well, correct?

7 A. Correct.

8 Q. And you didn't break it down in this  
9 interrogatory response to show how much was true  
10 charity versus how much was a bad debt or denial or an  
11 administrative adjustment as referenced in this  
12 response, correct?

13 A. No, we did not.

14 Q. Do you still have Exhibit 79 up there,  
15 Mr. Shaheen?

16 A. Okay.

17 Q. Mr. West asked you some questions about this  
18 too, and this is the most recent audited financials  
19 for Strategic Behavioral Health, correct?

20 A. Correct.

21 Q. And how many beds total, across the board,  
22 does Strategic Behavioral Health have, including  
23 inpatient, residential?

24 A. Total beds to the company? 710 today.

25 Q. And do you know how many -- when this document

1 was prepared, what the total bed count for all of your  
2 facilities would be?

3 A. 710. We haven't had a change when this  
4 document was prepared.

5 Q. And Mr. West talked to you about Page 17.  
6 Could you turn there, please?

7 A. Uh-huh.

8 Q. And up at the top it lists out the breakouts  
9 of your payments, again, Medicare, Medicaid,  
10 commercial, self-pay, and breaks down how those were  
11 allocated in your financial statements. Do you see  
12 that?

13 A. Correct.

14 Q. And then down at the bottom there's a Note 8  
15 here, and it says "Charity Care." Do you see that?

16 A. I do.

17 Q. And it talks about how the company, while it  
18 maintains a list of charity care providers, you can't  
19 really allocate specific expenses related to that, and  
20 so your auditors, through you, have reported that for  
21 the year 2014, your estimated direct and indirect  
22 costs for charity care was \$491,000. Do you see that?

23 A. Uh-huh.

24 Q. Yes?

25 A. I do see that.

1 Q. And then for 2013, it was \$485,000. Do you  
2 see that?

3 A. I do see that.

4 Q. And then turn back to Page 4, if you don't  
5 mind.

6 A. Okay.

7 Q. And your total expenses for 2014 were almost  
8 \$92 million. Do you see that?

9 A. I do see that.

10 Q. And so for your charity care, your direct and  
11 indirect costs were 491,000 out of a total of almost  
12 \$92 million in costs that you had for the year 2014;  
13 is that correct?

14 A. Correct.

15 Q. And that would work out not to 5 percent,  
16 Mr. Shaheen, but that's more like .5 percent, correct?

17 A. Of --

18 Q. Dividing 92 million?

19 A. Of expenses?

20 Q. Yes, sir.

21 A. Oh, the question on Page 27 is of charges.  
22 Those are completely different. So the percentage  
23 that we reported is of charges.

24 Q. Right. And I'm asking you --

25 A. That was the question.

1 Q. I'm asking you a different question now,  
2 Mr. Shaheen.

3 A. Okay.

4 Q. I'm asking that -- your audited financials  
5 were prepared by an independent auditor, correct?

6 A. Right.

7 Q. And you're not a CPA, are you?

8 A. Nope.

9 Q. And your audited financials here report that  
10 \$491,000 of your costs, your expenses, were related to  
11 charity care in the year 2014.

12 A. Correct.

13 Q. And your total costs for the year 2014 were  
14 \$92 million, correct?

15 A. Correct.

16 Q. Okay. I'm going to move on from those.  
17 I'd like to go back in time to when this project  
18 was sort of still a twinkle in your eye, so to speak,  
19 and talk about in the summer of 2012, you retained a  
20 statistician from the University of Vanderbilt,  
21 correct?

22 A. He was an MBA student studying -- getting his  
23 MBA at Vanderbilt and was studying statistics, yes.

24 Q. And that was Mr. Thompson, correct?

25 A. Correct.

1 Q. And you retained Mr. Thompson because you  
2 wanted to perform a nationwide analysis to identify  
3 particular markets that you may be interested in going  
4 and exploring, correct?

5 A. Correct.

6 Q. And you told him at the outset that there  
7 were certain markets you didn't want to go to, some  
8 were either too highly regulated; some, the cost of  
9 building was too high; in California there are too  
10 many earthquakes for your liking. So for all those  
11 reasons, there were parts of the country you told him  
12 "Don't look at."

13 A. That's right.

14 Q. But the rest of the country, you said to go  
15 out and find regions that contain 300,000 people or  
16 more and then come back to me and we'll explore these  
17 particular areas and see whether or not they're good  
18 choices for your company to build new hospitals,  
19 correct?

20 A. Correct.

21 Q. Mr. Shaheen, I've handed you a document that  
22 was premarked as Exhibit 6, and it's about -- looks  
23 like a 12-, 13-page document. Do you recognize this  
24 document?

25 A. I do.

1 Q. And is this a summary of the analysis that was  
2 prepared by the Vanderbilt statistician, Mr. Thompson,  
3 that you retained?

4 A. The first page is, yes.

5 Q. Okay. And we'll go through all these pages a  
6 little bit, but this entire document, in essence, was  
7 part and parcel of the analysis that Mr. Thompson did,  
8 correct?

9 A. It was, yes.

10 MR. SWEARINGEN: Your Honor, I'd ask that  
11 this be made Exhibit Number 6 to our proceedings.

12 THE COURT: And you said the individual's  
13 name was -- were you saying Thompson or Thomas?

14 MR. SWEARINGEN: Mr. Thompson.

15 THE COURT: Okay. Exhibit 6 is the  
16 analysis that was performed by Mr. Thompson in the  
17 summer of 2012 that he did on behalf of SBH.

18 (Marked Exhibit No. 6.)

19 BY MR. SWEARINGEN:

20 Q. Mr. Shaheen, so you sent Mr. Thompson out to  
21 identify these various areas of 300,000 people or  
22 more, these regions in the country, correct?

23 A. Correct.

24 Q. And if you turn to the last page of this  
25 document which has got a number on the bottom

1 right-hand of 3155, one of the regions of the country  
2 that Mr. Thompson identified was the Tri-Cities area,  
3 correct?

4 A. Correct.

5 Q. And Page 3155, which is the last page here,  
6 this shows sort of a summary -- and we'll go into a  
7 little bit more detail about it, but sort of the  
8 summary of all the work he did related to the  
9 Tri-Cities areas, correct?

10 A. Correct.

11 Q. And under the first breakdown there, it's got  
12 the population that makes up this region that he has  
13 labeled the Tri-Cities area. And you'll note there  
14 that both Johnson City and Kingsport are listed,  
15 correct?

16 A. Correct.

17 Q. So at least as of the time that this was  
18 prepared in the summer of 2012, your company was still  
19 considering Johnson City as part of the rationale for  
20 constructing a new psychiatric hospital in the  
21 Tri-Cities area, correct?

22 A. Not as a company. The intern identified  
23 that market. We didn't, as a company, identify that  
24 market. That was what we charged him with, was to  
25 identify that market, so yes.

1 Q. Well, you retained Mr. Thompson on your behalf  
2 to perform this analysis, correct?

3 A. Right.

4 Q. And prior to him performing this analysis, you  
5 had never been to the Tri-Cities area --

6 A. Correct.

7 Q. -- in any professional capacity, correct?

8 A. Correct.

9 Q. And no one on behalf of SBH had ever been to  
10 the Tri-Cities in any professional capacity to  
11 evaluate it for psychiatric needs, correct?

12 A. Correct.

13 Q. And so this was the first time anyone either  
14 at your company or on behalf of your company had  
15 analyzed the Tri-Cities area that you're aware of?

16 A. Correct.

17 Q. And, again, at least as part of this summary  
18 page, he is -- Mr. Thompson is still including Johnson  
19 City as part of the rationale or analysis of whether  
20 or not a psychiatric hospital should be built in the  
21 Tri-Cities area, correct?

22 A. Correct.

23 Q. In addition to the Tri-Cities, Mr. Thompson  
24 identified 94 other possibilities that contained  
25 300,000 or more people, correct?

1 A. That is correct.

2 Q. And so from these 94-some-odd -- 95-some-odd  
3 metropolitan regions, you needed to go in and figure  
4 out whether or not there were existing psychiatric  
5 resources in those areas, correct?

6 A. That's correct.

7 Q. And you spoke a little bit about this under  
8 your direct examination, but part of that was applying  
9 a 30-bed-per-100,000-people formula to these areas,  
10 correct?

11 A. That is correct.

12 Q. And as you mentioned, that's also the formula  
13 that's part of the State Health Plan here in  
14 Tennessee, correct?

15 A. Right.

16 Q. And it's the formula that's applied by the  
17 HSDA as part -- Health Services and Development Agency  
18 as part of their analysis under the State Health Plan,  
19 correct?

20 A. Correct.

21 Q. And so in order to figure out this 30 beds per  
22 every 100,000 people, Mr. Thompson had to go dive into  
23 these markets and look at JAR reports and regulatory  
24 data and whatever the case may be and identify who the  
25 existing providers were in each of these regions,

1 correct?

2 A. Correct.

3 Q. And if you still look at that last page, 3155,  
4 there's a section there, the third section, for acute  
5 competition. Do you see that?

6 A. I do.

7 Q. And sitting there front and center on that  
8 list, the first one listed is my client's psychiatric  
9 hospital, Woodridge in Johnson City, correct?

10 A. Sure.

11 Q. In addition, it's got additional resources  
12 that are listed here: Wellmont Bristol, Ridgeview,  
13 Takoma Regional, and Sycamore Shoals. Do you see  
14 that?

15 A. I do.

16 Q. And the reason why those were identified  
17 as part of this analysis is because you had told  
18 Mr. Thompson to go and look for any psychiatric beds  
19 within a 60-mile radius, correct?

20 A. That's correct.

21 Q. And all of these beds are located within 60  
22 miles of the Tri-Cities region, correct?

23 A. I'm pretty sure, yes.

24 Q. And so, again, at least as far as Mr. Thompson  
25 is concerned, when he's preparing this analysis, he's

1 not looking at Johnson City, but he's also looking at  
2 Woodridge Hospital, he was looking at Wellmont  
3 Bristol, Ridgeview, Takoma, and Sycamore Shoals when  
4 trying to come up with a rationale for whether or not  
5 a new psychiatric hospital is needed in the  
6 Tri-Cities, correct?

7 A. That is correct.

8 Q. If you turn to Page 3151, this is the ranking  
9 system that Mr. Thompson came up with, and this is  
10 based on taking the population and dividing it by a  
11 30-beds-per-100,000 formula and applying the total  
12 beds in the community and then figuring out what the  
13 bed need was for each of those, correct?

14 A. Correct.

15 Q. And here, Tri-Cities area, which Johnson City  
16 is listed as the first one under this particular  
17 analysis, is Number 34 on that list, correct?

18 A. That is correct, for the bed-need ranking.

19 Q. And there is a section over here of notes  
20 that lists sort of particular acute issues in any  
21 particular region. Some don't have any residential  
22 facilities. Some don't have any geropsych beds. Some  
23 don't have any youth or adolescent beds. And the  
24 section for notes next to Tri-Cities is blank,  
25 correct?

1 A. Correct.

2 Q. So after you and Mr. Thompson had analyzed  
3 these various regions for just blanket bed-need  
4 formula, you went a step further, right? You came up  
5 with some other metrics that you wanted him to apply  
6 to these areas to further analyze the appropriateness  
7 or the lack of a need for a new psychiatric facility  
8 in these regions, correct?

9 A. Not to analyze, necessarily, need but to  
10 analyze the viability of a psychiatric hospital.

11 Q. Sure. And from your business plan  
12 perspective, there are things that go into making a  
13 decision on where to put a hospital other than whether  
14 it's actually needed in that community, correct?

15 A. Right. There are additional factors that  
16 determine -- once a need is determined, there's a lot  
17 of additional factors to determine whether it can be  
18 successful or not.

19 Q. If you'll turn to the first page of this  
20 document, which is 3143. It's, unfortunately, fairly  
21 small, but at the top there, it's got all of the  
22 various criteria that you told Mr. Thompson to apply  
23 in evaluating these regions, correct?

24 A. That is correct.

25 Q. And these were your criteria that you came up

1 with and told him to use, correct?

2 A. I did. In my, at this point, 24 years of  
3 working, yeah, these were the important items.

4 Q. And on this list -- unfortunately, they're not  
5 numbered, and for confidentiality purposes, this was  
6 produced to us with all the other locations blacked  
7 out, but on this total list, Tri-Cities comes in  
8 where, about 14 maybe?

9 A. Somewhere around -- the numbers are gone,  
10 but -- 15.

11 Q. 15. And that's 15 out of now 27 areas that  
12 have been sort of whittled down to come up with this  
13 analysis, correct?

14 A. Correct.

15 Q. And if you flip over three pages to 3145,  
16 this is what has been labeled as "Market Demand."  
17 It's a little bit different than just the need  
18 analysis that was performed that we looked at a  
19 little bit earlier. This actually combines a couple  
20 of factors. One is need. One is whether there's an  
21 unmet need. And also it's taken into consideration  
22 whether it's a CON state or not, correct?

23 A. Correct.

24 Q. And on this list for market demand, the actual  
25 need for a new psychiatric facility in a particular

1 region, the Tri-Cities comes in at 22nd, I believe --  
2 excuse me -- 23rd; is that correct?

3 A. If you've counted those. Would you like me to  
4 count those to confirm?

5 Q. You can take my word for it, if I'm off by one  
6 or two --

7 A. Okay.

8 Q. So based on this, there are only four regions  
9 that you had Mr. Thompson study, based on this  
10 analysis, that had better psychiatric bed access than  
11 the Tri-Cities; is that correct?

12 A. For this metric of market demand. I wouldn't  
13 say better access or -- by the need formula that we  
14 used, which was pure bed need, and then the unmet  
15 need, which there was a -- why he was a statistician  
16 was because there was a formula and a calculation he  
17 weighted as to unmet need from a percentage basis. So  
18 by those two metrics, yes.

19 Q. And, again, these are metrics that you came up  
20 with, correct?

21 A. Correct. But you used the term "access," and  
22 I would say that's not accurate.

23 Q. Well, let me, then, be accurate. Based on  
24 market demand as related in this analysis, the  
25 Tri-Cities was the 23rd out of the 27 areas that you

1 were studying, correct?

2 A. Correct.

3 Q. And then if you turn to the next page, 3146,  
4 this is a competition analysis, and if we look back at  
5 that summary page that showed the various facilities  
6 that are geographically disbursed -- and we looked at  
7 them a little bit earlier on Map Number 8, but this  
8 page of the analysis is trying to analyze what  
9 competition exists in the Tri-Cities area, correct?

10 A. Correct.

11 Q. And here, less competition is better and more  
12 competition is worse, correct?

13 A. Right.

14 Q. And on this listing, the Tri-Cities came in  
15 at, I believe, 21st. Does that look about right to  
16 you?

17 A. Looks correct.

18 Q. And so based on this analysis of competition,  
19 there were only six areas in the country that you were  
20 studying that had more competition than the Tri-Cities  
21 area?

22 A. Correct.

23 Q. And the next page is 3147, and here you're  
24 looking at building costs, costs to your bottom line  
25 when you go in to build a facility. And Tri-Cities

1 actually did pretty well here. They were about 10th,  
2 right?

3 A. Correct.

4 Q. And then the next page, 3148, was the staffing  
5 determination. You talked a little bit about this on  
6 your direct examination, but this looks at a variety  
7 of things. First it looks at the availability of  
8 staffing, whether there are educational institutions  
9 located at or near or in the region, correct?

10 A. Yes.

11 Q. But it also looks at whether the state has  
12 staffing ratios that may require you to keep more  
13 staff in your facility than you otherwise might do  
14 normally, correct?

15 A. Correct.

16 Q. It also takes into account the costs or the  
17 salaries and wages you're going to be paying your  
18 staff, correct?

19 A. That is correct.

20 Q. And here, Tri-Cities came in at Number 2?

21 A. Number 2, that's correct.

22 Q. Because Tennessee has lower staff ratios, the  
23 staff here is pretty cheap, and there's a lot of them  
24 available in the region, correct?

25 A. I wouldn't say lower staff ratios. I would

1 say they have staff ratios more complementary to how  
2 we would operate versus mandated staff ratios that  
3 might be different than how we would operate our  
4 hospitals.

5 So when you -- staff ratio wasn't just lower  
6 or higher; it's we have a standard in which we  
7 operate. And if the state mandated was closer to  
8 ours, then that would get a higher score than if they  
9 were farther away, probably low or high. In most  
10 cases it wasn't low, but low or high, because we  
11 believe in a standard of care for ratios.

12 So that's -- and, you know, I apologize. In  
13 my deposition I didn't realize -- you know, I thought  
14 more about exactly why those scores came the way they  
15 did; it's because they were closer to our internal.  
16 That's how you got a higher score under "Ratio."

17 Q. Okay. That was a little bit different than  
18 how you answered that question during your deposition.

19 A. I realize that. I realize that.

20 Q. And when we're talking about staffing, for  
21 instance, you have -- you talked about during your  
22 direct when you have your unit modules of your  
23 different hallways for different folks, you've got  
24 one nursing station sort of monitoring two different  
25 hallways, correct?

1 A. Correct.

2 Q. For instance, in the Kingsport facility,  
3 you're going to have one nursing station monitoring  
4 your children and your substance abuse patients,  
5 correct?

6 A. Correct.

7 Q. But we can agree that staffing was by far the  
8 highest that the Tri-Cities area ranked in any of the  
9 analyses that was performed by Mr. Thompson?

10 A. Absolutely.

11 Q. So essentially from the summer of 2012 until  
12 the late summer of 2013, this analysis essentially sat  
13 on the shelf. And then in late 2013, Mr. Garone, who  
14 we'll hear from later, I presume, was brought in from  
15 your facility in Las Vegas to become your business  
16 development person; is that fair?

17 A. Yes, except for it didn't sit on the shelf.  
18 We've been working this list since the summer of 2012.

19 Q. Well, it sat on the shelf as it relates to the  
20 Tri-Cities area, correct?

21 A. Absolutely, yes.

22 Q. And then when Mr. Garone came in in September  
23 of 2013, late August, you put him in charge -- you put  
24 this on his desk and you put him in charge of  
25 evaluating the Tri-Cities area, correct?

1 A. I did. I did.

2 Q. And, to your knowledge, Mr. Garone had no  
3 experience filling out a CON application in Tennessee,  
4 correct?

5 A. He had not.

6 Q. And previously he had been in sales and  
7 marketing out in Las Vegas, correct?

8 A. In this industry, yes.

9 Q. And he had never operated or done any business  
10 in the psychiatric field in Upper East Tennessee,  
11 correct?

12 A. Not in Upper East Tennessee, no.

13 Q. In fact, to your knowledge, Mr. Garone had  
14 never even been to the Tri-Cities area prior to coming  
15 to work for you in Memphis in 2013?

16 A. Not to my knowledge, no.

17 Q. And so in September and early October 2013,  
18 you sent Mr. Garone off to evaluate the Tri-Cities for  
19 the possibility of building a psychiatric hospital  
20 there, correct?

21 A. Correct.

22 Q. And, Mr. Shaheen, if you could take a look at  
23 that for a moment, please.

24 A. (Reviewing document.)

25 Q. Do you recognize that email stream and the

1 document that's attached to it?

2 A. You say recognize that? Yes, I've seen this  
3 before.

4 Q. And this was an application that Mr. Garone  
5 sent to the Johnson City, Tennessee, Industrial  
6 Development Board on or about October 1, 2013. Does  
7 that look about right?

8 A. That's correct.

9 Q. And this was a document that was prepared in  
10 the normal course of SBH's business, correct?

11 A. We do these applications in markets everywhere  
12 we go. We meet with multiple agencies, and it's part  
13 of our introductory process to a community. We  
14 introduce ourselves and who we are and meet with  
15 economic developments from around the entire region.  
16 We do that.

17 Q. Mr. Shaheen, I've looked high and low through  
18 your discovery responses and I didn't see a similar  
19 application like this to Kingsport, Tennessee. Do you  
20 know if that was just not produced to us, or did one  
21 not exist?

22 A. I don't know. If one didn't exist, it would  
23 mean that the question was asked and they weren't --  
24 it wasn't available or we had to file with the state  
25 -- or the county might -- I mean, every sort of

1 circumstance is different, so I wouldn't know.

2 I wasn't part of that process in terms of what  
3 happened in Kingsport versus Bristol versus, you know,  
4 whatever it might be -- whatever the city name might  
5 be in terms of talking with economic development.  
6 He's charged with -- I charge him with talking to  
7 everyone.

8 Q. Sitting here today, do you know whether or not  
9 SBH, your company, applied for any type of industrial  
10 tax credits --

11 A. I don't off the top of my --

12 THE COURT: Let him finish his question.

13 BY MR. SWEARINGEN:

14 Q. Do you know whether or not SBH applied for any  
15 industrial tax credits with anyplace in Upper East  
16 Tennessee or Southwest Virginia other than Johnson  
17 City?

18 A. I do not know.

19 MR. SWEARINGEN: I'd ask that that be  
20 marked as Exhibit 380.

21 THE COURT: Exhibit 380 will be marked  
22 a series of emails of Mike Garone, and the date is  
23 October 1st, 2013. Attached to the email is a Johnson  
24 City, Tennessee, Industrial Development Bond Board  
25 Incentive Application for New and Expanding Business.

1 (Marked Exhibit No. 380.)

2 BY MR. SWEARINGEN:

3 Q. And the date of that exhibit, Mr. Shaheen,  
4 again, is October 1, 2013, correct?

5 A. Correct.

6 Q. And, to your knowledge, had Mr. Garone been to  
7 the Tri-Cities area prior to filing that application?

8 A. You know, I don't know the dates. I'm sorry.

9 Q. Well, let me see if I can help you.

10 A. I think you do.

11 Q. And I promise that I'm not purposely making  
12 these exhibits smaller and smaller.

13 MR. SWEARINGEN: This is Number 14 in  
14 your binder, Your Honor. I have a spare copy if you  
15 need it.

16 BY MR. SWEARINGEN:

17 Q. Mr. Shaheen, this was marked as Exhibit 14 to  
18 your deposition. And we talked about this when I came  
19 down and talked with you in May, correct?

20 A. Correct.

21 Q. And this document contains the total sum and  
22 substance of the meetings that took place between SBH  
23 representatives and individuals in the Tri-Cities  
24 area, correct?

25 A. Yep, pretty large list. I think it's

1 comprehensive.

2 Q. To your knowledge, nobody's missing off this  
3 list, correct?

4 A. Not to my knowledge.

5 Q. And, to your knowledge, the dates that are  
6 listed here in the meeting date column, those are all  
7 true and correct to the best of your knowledge?

8 A. Yes.

9 Q. And you'll see, and I'll represent to you so  
10 you don't have to get out the magnifying glass, this  
11 first meeting date that's listed on any of these  
12 meetings is October 9th, 2013, so approximately one  
13 week after the email we just saw with the application  
14 to Johnson City. Does that sound about right to you?

15 A. It looks correct, yes.

16 Q. And Mr. Garone went up to the Tri-Cities area  
17 October 9th and 10th, 2013, to meet with some folks in  
18 the Tri-Cities area, correct?

19 A. Correct.

20 Q. And you didn't go with him on that trip,  
21 correct?

22 A. I did not. I'm pretty sure I did not.

23 Q. And just looking at this list, the very top  
24 one is Wellmont Health System, Ms. Sue Lindenbusch.  
25 She's the vice president at Wellmont. He met with

1 her, it says here, 10/10/2013. Do you see that?

2 A. I do.

3 Q. Do you know where Ms. Lindenbusch's office is?

4 A. I do not. I don't physically know where she's  
5 located.

6 Q. Okay. NHC HealthCare is the next one.  
7 Mr. Adams and Mr. Flemmer who are with NHC HealthCare,  
8 he met with them on 10/9/2013. Their office is in  
9 Johnson City, correct?

10 A. If he says that they are here or if that's, in  
11 fact, where they are, I just wouldn't know. Sorry. I  
12 didn't study office locations of folks.

13 Q. Well, the Journey Center is the next one here.  
14 Ms. Sybil Smith, she's a therapist. Met with her on  
15 October 9th, 2013, and I'll represent to you that she,  
16 actually, is in Kingsport.

17 A. Okay.

18 Q. And then there's meetings with Frontier  
19 Health, Ms. Stephanie with the Crisis Response Team  
20 and Teresa Kidd and Randall Jessee on October 10th,  
21 2013, and I'll represent to you that their offices are  
22 in Johnson City.

23 A. Okay.

24 Q. Tennessee Department of Children's Services,  
25 Lucretia Sanders, October 10th, 2013. I'll represent

1 to you that her office is in Johnson City.

2 The Johnson City Police Department on  
3 October 10th, 2013, it should come as no surprise that  
4 they are located in Johnson City. And the Johnson  
5 City school system on the second page, 290, who is  
6 the -- with Ms. Snyder, who is the director of student  
7 services, 10/10/2013, also in Johnson City.

8 Those are all the meetings, at least as  
9 represented in this summary, that Mr. Garone had with  
10 representatives in the Tri-Cities area on October 9th  
11 and October 10th, 2013, correct?

12 A. The ones you just named?

13 Q. Yes, sir.

14 A. No. It doesn't represent all of the -- the  
15 list is all of the meetings.

16 Q. I'm talking specifically about October 9th and  
17 October 10th.

18 A. Okay. Okay. Sorry. Yes, I assume so. If  
19 you ran off the dates to those, I just didn't follow  
20 the dates when you were listing those, but yes.

21 Q. And Mr. Garone, during this meeting on  
22 October 9th and October 10th, he didn't meet with  
23 anybody from Mountain States to your knowledge,  
24 correct?

25 A. Not that I know of.

1 Q. And that represents the total sum and  
2 substance of all the conversations that SBH  
3 representatives had with individuals in the Tri-Cities  
4 prior to you filing the application in this case in  
5 December of 2013, correct?

6 A. He made more than one trip. I guess that's  
7 why I'm -- I just want to make sure that -- don't know  
8 whether it was prior to, I mean, filing. But if this  
9 says not so -- because we filed in December; is that  
10 correct?

11 Q. Yes, sir.

12 A. So, yes. I understand.

13 Q. I know you don't know where these people are  
14 located, but you probably can tell me, out of this  
15 seven or eight stakeholders that are represented on  
16 this list that you met with prior to filing your  
17 application, do you know how many actually filed  
18 letters of support in favor of your application?

19 A. I do not know that. I don't.

20 Q. Did any of the stakeholders that Mr. Garone  
21 met with tell him, to your knowledge, that they  
22 thought that there needed to be a new 72-bed  
23 psychiatric hospital in Kingsport, Tennessee?

24 A. I don't know if they used the terms that you  
25 used, but he did receive significant conversations

1 with folks that there was a need for different  
2 populations. I think I testified to this in my  
3 deposition, that if you're sitting in front of a  
4 nursing home having that discussion or an assisted  
5 living facility, they're only going to be talking  
6 about the geriatric population. That's their  
7 particular need.

8 Why we meet with so many different  
9 stakeholders is to cover all of the populations to  
10 determine. So in terms of -- to say bed number or to  
11 say -- we just ascertained the need for the population  
12 that they were seeing or treating in their level of  
13 experience.

14 Q. Well, I ask, Mr. Shaheen, because I think you  
15 testified a little bit about this, but you've designed  
16 two prototype bed models, correct? One's a 72-bed and  
17 one's a 92-bed, correct?

18 A. Correct.

19 Q. The first hospital you ever built in  
20 Wilmington, that was a 72-bed prototype facility,  
21 correct?

22 A. That's correct. Well, it's not a prototype,  
23 but it was the first one.

24 Q. You also recently built a 72-bed hospital in  
25 College Station, correct?

1 A. That is correct.

2 Q. You're currently building a 72-bed hospital in  
3 Green Bay, correct?

4 A. That's correct.

5 Q. And then you've got 92-bed facilities in  
6 Raleigh and in Peak View, in Colorado, and 92 in  
7 Johnstown, Colorado, currently being built, correct?

8 A. Correct.

9 Q. So you have these two prototypes, one's a 72  
10 and one's a 92, correct?

11 A. I actually have three. I have a 94-bed one  
12 now as well, but yes.

13 Q. And here you decided to use the 72-bed  
14 prototype?

15 A. Based on the bed-need demand, yes.

16 Q. Okay. You spoke with Mr. West a little bit  
17 about -- well, you spoke to him a little bit about  
18 Woodridge's current occupancy percentage, correct?

19 A. I did.

20 Q. And, in fact, 85 percent is what SBH targets  
21 as its occupancy level for its facilities, correct?

22 A. Correct.

23 Q. And your Peak View facility in Colorado, for  
24 instance, runs at about 80 to 85 percent, correct?

25 A. It does.

1 Q. And your Wilmington facility actually runs  
2 about 98 percent?

3 A. It does.

4 Q. And you would agree that --

5 THE COURT: Mr. Swearingen, let me  
6 interrupt just for a minute. Did you want to make  
7 this an exhibit? You've moved off of it.

8 MR. SWEARINGEN: I do, Your Honor. I  
9 apologize. Thank you.

10 THE COURT: 14?

11 MR. SWEARINGEN: Yes, Your Honor.

12 THE COURT: All right. Next exhibit will  
13 be Exhibit 14 which shows meetings between SBH and  
14 individuals, companies or agencies in the Tri-Cities  
15 area.

16 (Marked Exhibit No. 14.)

17 BY MR. SWEARINGEN:

18 Q. Mr. Shaheen, you would agree that from a  
19 service line perspective, all the services that you  
20 project to offer at SBH-Kingsport are currently being  
21 offered by another provider in the Tri-Cities region,  
22 correct?

23 A. Correct.

24 Q. And from a service line standpoint, you'll be  
25 offering at SBH-Kingsport the same services that are

1 offered at Woodridge, for instance, to the best of  
2 your knowledge?

3 A. To the best of my knowledge, yes.

4 Q. And you don't have any criticisms of the  
5 clinical programming at Woodridge, correct?

6 A. I do not.

7 Q. You've never stepped foot inside that  
8 facility, correct?

9 A. I have not.

10 Q. And you talked with Mr. West about outpatient  
11 services that you may offer, and you and I talked  
12 about those for a while at your deposition. Currently  
13 you don't know what outpatient services you're going  
14 to be offering at the SBH-Kingsport facility, correct?

15 A. We do. We do. It's in our application, and  
16 we know -- we have offered partial hospitalization and  
17 intensive outpatient for all populations.

18 Q. But when we talked about this in your  
19 deposition, you agreed that it was going to be a  
20 game time decision once you actually got into the  
21 marketplace and determined, at that point, what  
22 services and what populations and what programs and  
23 whatnot would be decided at that time, true?

24 A. From an outpatient basis, I said it's a game  
25 time decision which one opens first, not whether it's

1 provided or not. We put in our application that we  
2 would provide all of those services. I said we don't  
3 open them all up at once and it's a game time decision  
4 as to which one of those gets opened up first. It's a  
5 process.

6 Q. Mr. Shaheen, changing topics for a moment, the  
7 Dobbs family are the majority owners of Strategic  
8 Behavioral Health, correct?

9 A. That's correct.

10 Q. And, for reference, the Dobbs family is a  
11 group of brothers and sisters that don't just own  
12 and operate psychiatric facilities, they've got car  
13 dealerships and beer distributorships and a variety of  
14 different companies, correct?

15 A. They have a -- they don't have any car  
16 dealerships. They have a truck dealership. But, yes,  
17 they own different businesses.

18 Q. And the Dobbs Management Services, that is the  
19 organization, the management company that manages all  
20 of the various Dobbs family endeavors?

21 A. It's the family office that manages their  
22 endeavors, yes.

23 Q. Okay. I want to pass to you what's previously  
24 been marked as Exhibit 10 and ask you to take a look  
25 at that, please.

1 A. (Reviewing document.)

2 Q. Do you recognize that document?

3 A. I do.

4 Q. And what is it?

5 A. This is a summary of the project in Kingsport,  
6 Tennessee, that we -- "we" being myself and Mr. Garone  
7 -- presented to Dobbs Management Services, my  
8 partners.

9 Q. And is it dated?

10 A. It is. January 10th, 2014.

11 Q. So to orient the Court, this would be about  
12 five or six weeks after you filed the application in  
13 this case, correct?

14 A. That is correct.

15 MR. SWEARINGEN: I'd ask this be marked  
16 as Exhibit 10 to our proceedings, Your Honor.

17 THE COURT: Exhibit 10 will be marked  
18 as Summary of the SBH-Kingsport Project dated --

19 Oh, you just said, Mr. Shaheen,  
20 January 10th, 2014, but there's a different date on  
21 the actual document in the left-hand corner, upper  
22 left-hand corner. Oh, wait a minute. I was on the  
23 wrong exhibit.

24 All right. This is 10. And it's dated  
25 January 10th, 2014.

1 (Marked Exhibit No. 10.)

2 BY MR. SWEARINGEN:

3 Q. And, Mr. Shaheen, as you were describing, this  
4 was a PowerPoint presentation that you and Mr. Garone  
5 put together so that you could drive over to the  
6 offices of the Dobbs Management Services folks and  
7 explain to them why you thought building a new  
8 hospital in Kingsport was a good idea, correct?

9 A. Informing them that we filed a Certificate of  
10 Need, yes.

11 Q. And explaining to them the rationale and the  
12 financial aspects of it and --

13 A. Correct.

14 Q. -- that you thought it was going to make some  
15 money?

16 A. Correct.

17 Q. And, in fact, the first page of this  
18 presentation is the financial summary for the proposed  
19 Kingsport facility, correct?

20 A. Correct.

21 Q. And you lay out some numbers here, but at  
22 the end of the day, it's your estimation and your  
23 presentation to these Dobbs folks that you thought you  
24 were going to have a 50 percent return on equity by  
25 Year 2 of the project, correct?

1 A. That is correct. I don't know that it's Year  
2 2. It probably is -- well, Year 2 of -- the end of  
3 Year 2 operation annualized, so -- because you'll be  
4 ramping up. We take the very end and then annualize  
5 that.

6 Q. Sure. The 53 census listed up here next  
7 to the 72 beds on Page 539, that's your pro forma  
8 estimated census at the end of Year 2, correct?

9 A. Correct.

10 Q. And based on that pro forma annualized, you  
11 were expecting a 50 percent net return on your  
12 investment?

13 A. That's correct. Yes.

14 Q. And then if you go forward to Page 542,  
15 this is a graph that you-all put together that shows  
16 various characteristics that you're describing as the  
17 rationale for this project, and three of these got  
18 "excellents." Do you see that?

19 A. I do.

20 Q. And the first "excellent" was that, as you  
21 explained earlier, TennCare actually reimburses for  
22 patients ages 21 to 65. And that was a good thing for  
23 your business model, correct?

24 A. Because -- what I was explaining, only current  
25 SBH market, because that's a market that we're not

1 normally, because of the IMD, able to treat, yes.

2 Q. So that was good for your financial model  
3 that you were going to be getting reimbursement from  
4 TennCare for these adults ages 21 to 65, true?

5 A. Correct.

6 Q. The other "excellent" was the staffing  
7 requirements that we talked about earlier, that there  
8 was no set ratio requirements other than two direct  
9 care per unit at all times, correct?

10 A. Correct.

11 Q. And the next one is the staffing, that overall  
12 it was Number 2 on the intern project, that was the --  
13 Mr. Thompson's analysis we talked about a little bit  
14 earlier, true?

15 A. That is correct.

16 Q. And that the staff cost is low, higher  
17 education is high.

18 And then the next page is 543, and it has a  
19 Kingsport catchment area. I'll move that up a little  
20 bit so we can see it. And here you've drawn a 25-mile  
21 radius around Kingsport and then a 50-mile radius  
22 around Kingsport, and you've labeled this slide  
23 "Kingsport Catchment Area," correct?

24 A. Correct.

25 Q. And this slide is intended to demonstrate

1 where you expected the patients for your new facility  
2 at Kingsport to come from, correct?

3 A. It was intended to demonstrate where we would  
4 staff from, as well as some patients would come from  
5 those areas.

6 Q. Mr. Shaheen, does the word "staffing" appear  
7 anywhere on this map?

8 A. It does not.

9 Q. And we can agree if you wanted to emphasize  
10 staffing, you could have just simply listed out the  
11 educational institutions that were available in these  
12 markets and degrees that they offered, correct?

13 A. We certainly could have.

14 Q. Well, in fact, you did. If you look back on  
15 Page 541, it says accessibility to staff ranked Number  
16 2 on the intern project, and it then lists out East  
17 Tennessee State University and Johnson City and all  
18 the degrees that they offer. Then it says King  
19 University, Bristol/Kingsport, nursing, psychology.  
20 Do you see that?

21 A. That's correct.

22 Q. And actually King University is in Bristol,  
23 correct? It's not in Kingsport, is it?

24 A. I don't know off the top of my head. I  
25 apologize.

1 Q. Do you know of any educational institution in  
2 Kingsport that offers nursing programs?

3 A. I don't know off the top of my head.  
4 Mr. Garone would, or hopefully would.

5 Q. Okay. So the sources for the staffing that  
6 you're so excited about are actually located in  
7 Johnson City and in Bristol, true?

8 A. The sources of the educators for that.

9 Q. True?

10 A. True.

11 Q. And those educational institutions are nowhere  
12 depicted on these maps, true?

13 A. They're not. As you point out, they were  
14 already depicted.

15 Q. Turn to the next page after these maps,  
16 however. It talks about Kingsport population data and  
17 bed need. Do you see that?

18 A. I do.

19 Q. And that's drawn straight from Mr. Thompson's  
20 analysis?

21 A. I'm pretty sure.

22 Q. And it just so happens that every single one  
23 of these counties that's listed here, which is the  
24 source of the population data and bed need, each one  
25 of these counties is located within the 50-mile radius

1 shown on your catchment area maps, correct?

2 A. It should be.

3 Q. And ironically you were at -- you've seen  
4 Dr. Collier's report in this case, correct?

5 A. I have.

6 Q. You were at her deposition when Mr. West asked  
7 her some questions?

8 A. I was.

9 Q. And Dr. Collier has come up with what she  
10 believes to be a reasonable proposed service area for  
11 your project. You understand that, correct?

12 A. I understand that she did that, yes.

13 Q. And do you understand how she came up with her  
14 reasonable service area?

15 A. Oh, no. I don't understand that at all.

16 Q. You aren't aware if Dr. Collier, because of  
17 health planning reasons that she's going to have to  
18 explain, that I don't truly understand -- she drew a  
19 35-mile radius around your site and identified all the  
20 counties that would draw -- she expected you to draw  
21 patients from at this location, correct?

22 A. If you say that's how she came up with it. I  
23 guess what I'm saying is I don't know how she -- what  
24 methodology she used to do that, so I couldn't answer.

25 Q. You don't know if she used a similar

1 methodology as referenced in this Kingsport catchment  
2 area site?

3 A. I don't know. I'm familiar she did it, but I  
4 don't -- couldn't say how she did it.

5 Q. On Pages 545 and 546 of this presentation to  
6 the Dobbs Management Service folks, there you analyze  
7 the competition existing in and around your proposed  
8 facility, correct?

9 A. Yes, we do.

10 Q. And on Page 545 you list out all the same  
11 places that Dr. Collier has listed out on her map:  
12 Clearview, Takoma, Magnolia Ridge, Woodridge,  
13 Ridgeview Pavilion. Those are all listed on your  
14 presentation, correct?

15 A. They are.

16 Q. And then on Page 546, again, it says here  
17 "Kingsport Competition," and it just so happens that  
18 the Kingsport competition slide, if you look there at  
19 the top, uses those same 25-mile and 50-mile radiuses  
20 that were included on this catchment area map, right?

21 A. Correct.

22 Q. And you define zero to 25 miles as your  
23 immediate market, correct?

24 A. That's what it says, yes.

25 Q. And included in your immediate market is

1 Ridgeview Pavilion as, at least, is listed on this  
2 competition slide, correct?

3 A. Correct.

4 Q. And that's even though Ridgeview Pavilion  
5 isn't technically in Sullivan County, it's -- you  
6 know, it's all of 1.8 miles into Virginia, it's still  
7 considered as part of your immediate market and  
8 competition as it relates to this slide, correct?

9 A. As it relates to this slide, yes.

10 Q. And then Woodridge and Magnolia Ridge, they're  
11 all of .2 miles outside your immediate market and  
12 .9 miles as related to the distances that you're using  
13 in these concentric circles, true?

14 A. I haven't done that math, but if you say so.  
15 I would believe that's pretty accurate.

16 Q. Well, I've actually seen some measurements  
17 that suggest that it's less than 25 miles to get to  
18 Woodridge from your facility, but let's just take this  
19 at face value and say it's 25.2.

20 A. Okay.

21 Q. Now, you still define it here as part of your  
22 secondary market, correct?

23 A. Correct.

24 Q. And, Mr. Shaheen, this is the proposed service  
25 area that SBH has come up with in this case. And we

1 can agree that this map is nowhere to be found in that  
2 presentation, correct?

3 A. Those counties are in this presentation.

4 Q. Depicted as a map of any sort?

5 A. Not in and of itself.

6 Q. As we're talking about areas where you're  
7 going to be able to get your patients from, your  
8 hospital is going to have admission criteria, correct?

9 A. We will.

10 Q. And nothing in those admission criteria are  
11 going to restrict SBH-Kingsport's ability to take  
12 patients from Washington County, Carter County, Unicoi  
13 County or Greene County, correct?

14 A. Nothing in the admission criteria.

15 Q. And if a patient shows up from Washington  
16 County at your doors and they otherwise meet admission  
17 criteria and otherwise meet whatever payment policies  
18 you have in place, they will be seen at the  
19 SBH-Kingsport facility if it's built, correct?

20 A. They could be, yes.

21 Q. And we talked a little bit -- if I can ask the  
22 court reporter to hand you Exhibit 11, please.

23 (Document passed to witness.)

24 BY MR. SWEARINGEN:

25 Q. And, Mr. Shaheen, you and Mr. West talked

1 about this. This is the pro forma document that  
2 you-all put together prior to filing your application  
3 in this case, correct?

4 A. Correct.

5 Q. And it's got a build year on the first page,  
6 and then starting on 274 it's got Year 1, and then  
7 starting on 279 it's got Year 2 and all of your  
8 expectations as to how your facility will operate  
9 during those time periods, correct?

10 A. That is correct.

11 Q. And you also talked about how, until we served  
12 you with some interrogatories asking you to explain  
13 how you came up with the 12 average daily census or --  
14 excuse me -- length of stay, average length of stay,  
15 that that was an error?

16 A. That's right.

17 Q. And you corrected that and sent us some new  
18 data --

19 A. Correct.

20 Q. -- after you found out you had put in the  
21 wrong average length of stay, correct?

22 A. Correct.

23 Q. And ultimately what ended up happening is  
24 here on the pro forma, it has your Year 2 admissions  
25 as of the end of the second year as being 1,425, but

1 actually that had to go up, right? In order to keep  
2 your numbers in line, you had to increase your  
3 admissions above -- north of 2,000, right?

4 A. In order for the patient days to match.

5 Q. Right. So you found out this mistake about  
6 the average length of stay, and so in order to correct  
7 that and make sure that the numbers still worked up,  
8 your admissions went from 1,425, as reflected in the  
9 application, to now you're thinking it's going to be  
10 north of 2,000, correct?

11 A. Correct.

12 Q. And there's no policy or procedure in place  
13 that would prohibit this facility from actually  
14 getting ramped up a little bit faster than that?

15 A. There isn't a policy. The only guidelines we  
16 use are our budget expectations, and then clinically  
17 the facility staff, medical directors and my home  
18 office staff confer and decide whether to veer from  
19 this ramp-up plan.

20 Q. Well, and one of the most recent facilities  
21 you built in College Station, they, in fact, hit this  
22 52 average daily census by the end of Year 1, right?

23 A. They did. They were clinically very, very  
24 sound and did a great job clinically, and so we  
25 allowed them to continue to grow.

1 Q. And there's nothing in the policies  
2 and procedures in SBH that would prohibit this  
3 application, if it moves forward and is completed,  
4 from reaching an average daily census of 52 by the end  
5 of Year 1 either, correct?

6 A. Assuming the clinical product was there and  
7 they were prepared and ready to take care of those  
8 patients, that's correct.

9 Q. And even if that didn't happen, it's still  
10 your goal, moving into Year 3 and Year 4, that this  
11 facility will be operating, at a minimum, your target  
12 of 85 percent occupancy, correct?

13 A. Well, the model we put together is this  
14 52.3, which I don't believe is 85 percent occupancy.  
15 I believe that's 70. And so our target for this  
16 facility is its census that we --

17 Q. Right, Mr. Shaheen, but you only projected out  
18 to Year 2, correct?

19 A. Correct.

20 Q. There's going to be a Year 3 of this facility  
21 if it operates, correct?

22 A. Correct.

23 Q. And there's going to be a year four,  
24 presumably, if it's approved, correct?

25 A. Right.

1 Q. And by Year 3 or year four, it's your hope and  
2 expectation that this facility will be operating at  
3 85 percent, correct?

4 A. I would like to see that, sure.

5 Q. And there's nothing in place to prohibit any  
6 of those patients, those 2,000-plus patients that  
7 you'll be seeing -- there's nothing in place to  
8 prohibit those patients from coming from Washington  
9 County, Greene County, Carter County or Unicoi County,  
10 correct?

11 A. In fact, I don't believe legally you can  
12 restrict those in admission criteria. I don't believe  
13 state licensure nor CMS will allow you to write from  
14 the admission criteria as to avoid that restriction.

15 Q. So the answer to my question is no?

16 A. Right.

17 MR. SWEARINGEN: Nothing further at this  
18 time, Your Honor.

19 THE COURT: Redirect?

20 MR. WEST: Your Honor, if I may approach  
21 the map.

22 THE COURT: Certainly.

23 REDIRECT EXAMINATION

24 BY MR. WEST:

25 Q. Mr. Shaheen, if you look at this Map 8

1 that's been displayed up here which is the so-called  
2 alternate service area, if you are a resident of  
3 Unicoi County, how do you get from Unicoi County up to  
4 Kingsport?

5 A. Not seeing the highways, I don't really know  
6 how that occurs from that given area. The map -- it's  
7 an interesting map in that you visually can see why we  
8 chose Kingsport. That map shows that there are no  
9 service providers to the east and all of those folks  
10 have to travel to the west. And so we have a  
11 philosophy of "go where they're not." As you can see  
12 by the providers there, they're not to the east, so  
13 that's part of what -- that map shows exactly why you  
14 would pick a service area like that, because those  
15 services aren't provided east.

16 Q. Where does Unicoi County lie in relation to  
17 Washington County?

18 A. It's on the other side, looks like to me.

19 Q. Which direction?

20 A. South, assuming that's the north, south, east,  
21 west. Yeah.

22 Q. And do you know what kind of beds are at this  
23 Sycamore facility that they referenced?

24 A. I think I can probably look it up. I don't  
25 off the top of my head.

1 Q. Well, do you know whether there's another full  
2 scale --

3 A. It's a geriatric, 12 beds.

4 Q. And what about this Takoma unit down in Greene  
5 County?

6 A. It is older adult as well, at least by my --  
7 you know --

8 Q. When you say "older adult," you mean  
9 geriatric?

10 A. Geriatric, yeah.

11 Q. And how big is it?

12 A. It is 16 beds by my information.

13 Q. How many beds are in Sycamore?

14 A. Sycamore is 12 beds.

15 Q. 12 geriatric beds. And Takoma is 16?

16 A. 16 geriatric beds.

17 Q. All right. And I noticed in one of these  
18 exhibits that you were asked about -- it's Exhibit 10.  
19 Have you got Exhibit 10, the presentation to the Dobbs  
20 family, to the Dobbs Management Group?

21 A. Uh-huh.

22 Q. Have you got it in front of you?

23 A. I do. What page?

24 Q. Look at Page 0546, 546.

25 A. Okay.

1 Q. You see this entity listed in the middle there  
2 in Washington County called Magnolia Ridge?

3 A. Correct.

4 Q. Do you see Magnolia Ridge listed anywhere on  
5 this map, Map 8?

6 A. I do not.

7 Q. Do you know what Magnolia Ridge is?

8 A. It's a substance abuse facility.

9 Q. So it's not a freestanding hospital, then?

10 A. It's not.

11 Q. All right. You've heard a lot of questions  
12 asked by Mr. Swearingen of you today about when this  
13 Certificate of Need application was filed.

14 A. Uh-huh.

15 Q. Do you know when it was deemed complete?

16 A. You know, I don't.

17 Q. But that would show up in the records of the  
18 Agency?

19 A. It would. It would. Sometime we had  
20 responses that we had to do and clarifications, which  
21 we did several.

22 Q. So at least as of the end of January,  
23 according to an earlier exhibit January 2014,  
24 Mr. Garone was still answering questions from the  
25 HSDA staff; is that correct?

1 A. That's correct.

2 Q. So it wasn't deemed complete until after he  
3 answered those questions; is that your expectation?

4 A. That is correct.

5 Q. So many of these meetings that are referenced  
6 on Exhibit 14 that Mr. Garone kept track of, they also  
7 take place in January 2014; is that correct?

8 A. That's correct.

9 Q. So, in other words, these meetings that are  
10 listed here that Mr. Swearingen was concerned about,  
11 many of them took place prior to your application  
12 being completed -- or this SBH-Kingsport application  
13 being completed?

14 A. That is correct.

15 Q. And Mr. Garone was still, on behalf of  
16 SBH-Kingsport, answering questions?

17 A. Correct.

18 MR. SWEARINGEN: Your Honor, I just would  
19 lodge an objection to the leading.

20 THE COURT: You got away with a little  
21 bit there.

22 MR. WEST: I know. It's late in the day.  
23 Maybe it's the warmth of the courtroom. I'm not sure.

24 Your Honor, I believe that's all the  
25 redirect I have.

1 THE COURT: Mr. Swearingen, anything  
2 further of this witness?

3 MR. SWEARINGEN: Just very, very briefly,  
4 Your Honor.

5 (Pause.)

6 Nothing further, Your Honor.

7 THE COURT: Mr. Shaheen, you can step  
8 down.

9 THE WITNESS: Thank you.

10 (Witness was excused.)

11 MR. WEST: If Your Honor please,  
12 with regard to the next witness, we plan on calling  
13 Mr. Cagle, our CFO, but he's not here, I don't think,  
14 and then we'll follow him with Mr. Sullivan, our  
15 expert. And in light of that, unless the Court  
16 objects, we don't have another witness lined up right  
17 now to go forward, and starting Mr. Sullivan would be  
18 a long process.

19 THE COURT: All right. Well, it's fairly  
20 late in the day. Did Day 1 go, in terms of numbers,  
21 what you expected?

22 MR. WEST: Yes, Your Honor, as far as  
23 we're concerned. We thought we would get Mr. Shaheen  
24 on and complete, and if Dr. Elliott could spare time  
25 from his travels, we'd get him on and complete. So

1 we're about where we thought we would be.

2 THE COURT: All right. That's good.  
3 Friday, in our pre-hearing conference, the issue came  
4 up about the affidavits. Did you-all resolve that, or  
5 is that something we need to take up?

6 MR. WEST: Your Honor, we did not resolve  
7 it, and so I'll be happy -- I'll be happy to go first,  
8 since I'm objecting to the affidavits on behalf of my  
9 client.

10 THE COURT: Well, let me ask this since  
11 we had some discussion about it in our pre-hearing  
12 conference a few days ago. There were two affidavits,  
13 Teresa Kidd and Karl Goodkin. Do each of the affiants  
14 live in East Tennessee, in Tri-Cities, particularly?

15 MR. SWEARINGEN: Yes, Your Honor.  
16 They're both in Johnson City.

17 THE COURT: All right. Under the rule  
18 that they were presented -- and I assume you did  
19 that before ten days, as the rule requires, and you  
20 responded, Mr. West, within seven that you wanted to  
21 cross-examine.

22 MR. WEST: Yes.

23 THE COURT: The next part of the rule  
24 refers to the party offering affidavits to make the  
25 affiants available for cross-examination, give the

1 other side an opportunity.

2 Have y'all done that, Mr. Jackson and  
3 Mr. Swearingen?

4 MR. SWEARINGEN: Your Honor, the proposal  
5 we've made, and it's one that we've done -- not  
6 Mr. West and myself personally, but what we've done  
7 in other cases is to do that telephonically by  
8 deposition. The Court does have at its discretion --  
9 I know Mr. West had suggested earlier, on Friday, that  
10 perhaps the Court needed to somehow hear it yourself  
11 in order to assess the credibility of the witnesses.  
12 The rules also provide that it's your discretion to  
13 hear any proof by telephone also.

14 I can't say right now whether or not we  
15 could arrange for that to be done during this week,  
16 but these folks do have important things to say and  
17 we'd like to do whatever we can to make sure they're  
18 heard by Your Honor.

19 I think the offering to do it by  
20 deposition meets the letter of the rule because it  
21 allows a cross-examination, and that transcript can  
22 then be submitted to Your Honor. I think that's the  
23 easiest thing to do because we could work that out  
24 amongst ourselves and figure out the schedule. Since  
25 it's a bench trial, the record can be left open, which

1 is done on a not irregular basis.

2 But if that is not palatable, the other  
3 option I think Your Honor has available is to get  
4 those scheduled and do telephonic cross-examinations  
5 where the Court could actually listen. I don't know  
6 if that's any better. We think that they're  
7 important, and we have complied and we have offered  
8 them, as the rule suggests, to be cross-examined, and  
9 the rule was not specific as to the manner in which  
10 that takes place. I think either one of those options  
11 would be a reasonable solution given the fact that  
12 these individuals are in Johnson City, not just for  
13 the witnesses but for the lawyers having to perhaps  
14 drive up there or something along those lines.

15 MR. WEST: Your Honor, we were presented  
16 with these affidavits, one, Thursday of the week --  
17 Thursday a week ago and the other one Tuesday, I  
18 believe, of last week. Now, Mr. Swearingen had told  
19 me there might be one -- they had a problem getting  
20 it. So, technically, we're not so concerned about  
21 that. He got it to us Tuesday, except that's part and  
22 parcel of our problem, to cross-examine them before  
23 trial, which, I assume, is most frequent. But we  
24 think Your Honor needs to be able to assess their  
25 credibility, and we even invoked the rule. So if it

1 occurs post-trial, then there's no certainty that the  
2 rule would be complied with.

3           And that's one of the reasons we wanted  
4 them here or to cross-examine them at the hearing,  
5 because the press -- this may be out in the press, any  
6 number of things could happen. But if we invoke the  
7 rule and we're entitled by statute to cross-examine  
8 them, the logical thing to do is to do it in the trial  
9 before Your Honor. And I think we have the time in  
10 the week to do it, and, you know, we're entitled to  
11 cross-examine them. Telephonically, I think you lose  
12 whatever the rules may say, the credibility  
13 determination aspect of it.

14           THE COURT: Well, the rule doesn't  
15 explicitly say that they have to be live. There's no  
16 reason that they can't testify by telephone. The  
17 Rules of Civil Procedure allow that also, correct?

18           MR. WEST: I assume so. I haven't  
19 actually seen the expression on telephonic recently,  
20 but -- it's been a while. But my concern is, again,  
21 the rule invocation. If they had done it pretrial and  
22 everything -- all the testimony would have occurred  
23 and be over with. But now the trial is underway and  
24 witnesses have testified. The rule, I think, is an  
25 issue as far as their testimony goes.

1 THE COURT: Well, they did do a pretrial  
2 -- the rule provides that after you say you want to  
3 cross-examine them, they have to make the individuals  
4 available. There has to be an opportunity for you to  
5 cross-examine them. And that's what I'm getting at,  
6 what offers were made for you to cross-examine them.

7 I don't think the rule contemplates just  
8 because you say I want to cross-examine them they  
9 have to bring them in the courtroom, for them to be  
10 present, and so I'm trying to find something in  
11 between that, where if Mr. Swearingen or Mr. Jackson  
12 can make them available by telephone -- we can do  
13 it one of two ways: They can testify in front of  
14 me in here and you can do your cross-examination,  
15 or you can do it by deposition and present that  
16 cross-examination, depending on the schedules.

17 I mean, there's been an indication,  
18 you-all in the pre-hearing conference mentioned that  
19 there might be some time when some experts aren't  
20 available and there might -- we might have to take a  
21 break.

22 That might be an ideal time for you-all  
23 to present their testimony by telephone with me being  
24 present or do it as a deposition and then provide the  
25 transcript.

1 MR. WEST: Well, Your Honor, I understand  
2 -- certainly I understand your point and I know  
3 they're good ones, but you had asked the question  
4 about what opportunities were given. Well, if we --  
5 if it happens, as happened with Dr. Goodkin's  
6 affidavit -- regardless of what the seven-day  
7 limitation says, if we get it on Tuesday and the  
8 trial starts on Monday and we're all doing trial  
9 preparation, we don't have any practical opportunity  
10 to cross-examine Dr. Goodkin, and we didn't have much  
11 more with Dr. Kidd.

12 THE COURT: Well, I understand you're  
13 getting ready, but the rule says seven days; it  
14 doesn't say 14. And maybe a litigator didn't write  
15 the rule and take that into consideration; that the  
16 week before there would be a lot of trial work, and I  
17 understand you're doing that.

18 MR. WEST: Right. I understand.

19 THE COURT: But I simply have to go by  
20 the language in the rule, and if the opportunity is  
21 made to cross-examine, and that's what -- these people  
22 it's not like they're here in town --

23 MR. WEST: That's true.

24 THE COURT: -- where you can say -- or  
25 nearby -- bring them in. We're looking at a situation

1 where they're approximately five hours away. And both  
2 of them are practicing physicians, I assume, which is  
3 another issue.

4 And so maybe, Mr. Jackson,  
5 Mr. Swearingen, you can get with the two of them and  
6 see what their schedules are for the rest of the week  
7 to appear, and if they appear by deposition before me  
8 in the hearing, if you want to do a direct or you can  
9 just rely on your affidavit, that's up to you, and  
10 Mr. West can do the cross-examination.

11 If that's somewhat difficult or near  
12 impossible to arrange, then the other alternative  
13 would be for Mr. West to do his cross-examination by  
14 deposition and he presents the transcript to me this  
15 week.

16 MR. WEST: Your Honor, I understand your  
17 ruling. If you would give us a chance to discuss  
18 this, because we have to make preparations for it.

19 THE COURT: I understand. I understand.  
20 That's why I wanted to today, since it was first day,  
21 to go ahead and address that and give you-all some  
22 opportunity to make some arrangements.

23 MR. WEST: Well, on our behalf, we  
24 certainly will confer with Mr. Jackson and  
25 Mr. Swearingen about it.

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THE COURT: Okay. So we'll be ready to  
start at 9:00.

(Proceedings adjourned at 4:18 p.m. to be  
reconvened at 9:00 a.m. on July 28, 2015.)

BEFORE THE TENNESSEE  
HEALTH SERVICES AND DEVELOPMENT AGENCY  
NASHVILLE, TENNESSEE

IN THE MATTER OF: )  
 )  
SBH-KINGSPORT, LLC, )  
 )  
Applicant, )  
 )  
vs. ) Docket No.  
 ) 25.00-126908J  
TENNESSEE HEALTH SERVICES )  
AND DEVELOPMENT AGENCY, )  
 )  
Respondent, )  
 )  
and )  
 )  
MOUNTAIN STATES HEALTH )  
ALLIANCE, )  
 )  
Intervenor. )  
 )  
\_\_\_\_\_ ) VOLUME 2 OF 5

TRANSCRIPT OF PROCEEDINGS

Taken before Administrative Law Judge Leonard Pogue

Commencing at 9:00 a.m.

July 28, 2015

**ORIGINAL**

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P R O C E E D I N G S

THE COURT: Good morning, everyone. Are we ready to proceed?

MR. JACKSON: Yes, Your Honor.

THE COURT: Call your next witness, Mr. West.

MR. WEST: Thank you, Your Honor. We call James Cagle to the stand.

JAMES CAGLE

was called as a witness, and after having been first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. WEST:

Q. Mr. Cagle, would you state, for the record, your full name and position, please, sir.

A. James Walter Cagle, CFO, Strategic Behavioral Health.

Q. And how long have you been in that -- when were you hired for that position?

A. February of 2014.

Q. And did you work for Strategic Behavioral Health before then as an employee?

A. I did not.

Q. All right. So you weren't involved in the CON application drafting?

1 A. That's correct.

2 Q. Could you also state for the Court your  
3 education and professional designation?

4 A. Sure. Yes. Graduated from Mississippi State  
5 University in 1991 with a Bachelor of Accounting  
6 degree. I've been a CPA since 1993.

7 Q. And you're currently a CPA licensed in  
8 Tennessee?

9 A. Yes.

10 Q. And what are your job duties as the CFO of  
11 Strategic Behavioral Health?

12 A. My job duties are to oversee the financial  
13 operations of the company as a whole. It involves  
14 a lot of duties: managing cash flows; managing the  
15 whole, full accounting process.

16 Q. And, as you know, Strategic Behavioral Health  
17 has several projects underway of new construction or  
18 new development.

19 A. Correct.

20 Q. And what is your view of the company's  
21 capability of carrying out those projects?

22 A. I think we have a very good process and we  
23 have -- you know, it's definitely doable. We have a  
24 lot of availability under our line of credit and our  
25 financing.

1 Q. When you say "availability," availability of  
2 what?

3 A. Availability of borrowings.

4 Q. Cash?

5 A. For cash flow.

6 Q. You're talking about borrowing money, right?

7 A. Correct.

8 Q. And would you describe sort of the borrowing  
9 structure, if you will, of where the money would come  
10 from and things available to the company?

11 A. Sure. We have up to \$150 million of credit  
12 facility available to us. Part of that is made up  
13 of a \$70 million original balance loan. We have  
14 a \$10 million revolver, and then we have up to a  
15 \$70 million, on top of that, development line that  
16 is used to fund projects.

17 Q. And currently can you estimate approximately  
18 how much cash would be available to the company under  
19 that structure?

20 A. The availability I have under the \$150 million  
21 credit facility now would be about \$67 million  
22 available to us.

23 Q. What kind of cash flow does the company have  
24 on an annual basis currently?

25 A. From an operating cash flow of about 16-,

1 \$17 million.

2 Q. Is that cash above expenses?

3 A. That is operating cash flow, yes.

4 MR. WEST: All right. Your Honor, if I  
5 may approach the witness briefly.

6 THE COURT: Certainly.

7 BY MR. WEST:

8 Q. Mr. Cagle, I'm going to show you a document  
9 marked Exhibit 79 and ask you if you have seen that  
10 before, please, sir.

11 A. Yes.

12 Q. And what is that document?

13 A. That is the 2014/2013 audited financial  
14 statement.

15 Q. And who prepared it?

16 A. Horne, LLP.

17 Q. What is Horne, LLP?

18 A. They are a CPA firm.

19 Q. Are they based in Memphis?

20 A. They're actually based out of Ridgeland,  
21 Mississippi.

22 Q. All right. And does that document describe  
23 the bank lending structure that you mentioned just a  
24 minute ago for Strategic?

25 A. It does.

1 Q. And how often does Strategic Behavioral Health  
2 get audited?

3 A. Every year.

4 Q. So what is your view of whether Strategic  
5 Behavioral Health has the financial resources to carry  
6 out a project in Tennessee costing approximately  
7 \$12 million?

8 A. I would say very good.

9 Q. Based on what?

10 A. Based on our operating cash flows as we  
11 currently have them, as well as the availability of  
12 cash to us.

13 Q. All right. And do you know right offhand how  
14 many hospitals SBH currently operates?

15 A. Yes. We currently operate eight.

16 Q. And how many are under development in terms of  
17 actual construction?

18 A. As far as under construction, we have two in  
19 process.

20 Q. And are there new ones coming online?

21 A. There could be, yes.

22 Q. All right. So from the standpoint of  
23 whether -- you are a CPA in Tennessee?

24 A. Yes.

25 Q. That's what you said. And how many years have

1 you actually worked in the CPA practice?

2 A. About 22, almost 23 years.

3 Q. And in your role as the CFO for Strategic,  
4 what is your view, if you have one, of whether  
5 Strategic Behavioral Health through SBH-Kingsport,  
6 LLC, can economically establish and maintain the  
7 project proposed by the company up in Kingsport,  
8 Tennessee?

9 A. I think a very good likelihood of doing that,  
10 based on our financial status.

11 Q. And your financial status is reflected both in  
12 your testimony today and in the audit?

13 A. Yes. Yes, sir.

14 MR. WEST: All right. Your Honor, I  
15 believe that's all the questions I have for Mr. Cagle.

16 THE COURT: Cross-examination?

17 CROSS-EXAMINATION

18 BY MR. SWEARINGEN:

19 Q. Good morning, Mr. Cagle.

20 A. Good morning.

21 Q. My name's Travis Swearingen. We haven't had  
22 the opportunity to meet. I'm one of the lawyers for  
23 Mountain States in this case.

24 You don't know really anything about the  
25 Kingsport project we're here today to talk about,

1 correct? You haven't done any independent analysis  
2 of --

3 A. No.

4 Q. -- the financial aspects of that project,  
5 correct?

6 A. Correct.

7 Q. You also haven't done any analysis of the  
8 Tri-Cities area to determine whether or not there's  
9 any less costly alternatives that may be able to  
10 provide psychiatric services in that community other  
11 than building a new 72-bed hospital?

12 A. Correct.

13 Q. I have looked through some of your financial  
14 documents. You would agree that whenever your company  
15 builds a new hospital, there are going to be a certain  
16 amount of the expenses and costs that are associated  
17 with that build that are fixed, correct?

18 A. Correct.

19 Q. And then there are going to be certain costs  
20 that are variable based on what your census level is,  
21 correct?

22 A. Correct.

23 Q. And based on my review of some of the  
24 pro formas that have been distributed and some of the  
25 other financial documents, it looks like, for your

1 company, the fixed costs to variable costs runs  
2 somewhere around 35 to 40 percent. Does that sound  
3 about right?

4 A. Yes.

5 MR. SWEARINGEN: Permission to approach,  
6 Your Honor.

7 THE COURT: You may.

8 BY MR. SWEARINGEN:

9 Q. Mr. Cagle, the exhibit that Mr. West was  
10 asking you about --

11 A. Yes.

12 Q. -- if you could turn to Page 17 of that  
13 document.

14 A. Okay.

15 Q. Do you see Note 8 down there at the bottom?

16 A. Yes.

17 Q. Under "Charity Care"?

18 A. Uh-huh.

19 Q. It says there that "The Company" -- and I  
20 presume that means SBH, right?

21 A. Correct.

22 Q. So SBH maintains records to identify and  
23 monitor the level of charity care it provides. Did I  
24 read that correctly?

25 A. Yes.

1 Q. And is that true, that SBH maintains --  
2 identifies and monitors the level of charity care it  
3 provides?

4 A. Yes.

5 Q. The next sentence reads that "These records  
6 include the amount of charges foregone for services  
7 and supplies furnished under its charity care policy."  
8 Did I read that correctly?

9 A. I'm sorry. Can you repeat that one more time?

10 Q. I'm sorry. The next sentence right there:  
11 "These records include the amount of charges foregone  
12 for services and supplies furnished under its charity  
13 care policy."

14 A. Yes.

15 Q. And that's true also, that your company  
16 maintains records that shows how much charity care it  
17 provides on an annual basis, correct?

18 A. That is correct.

19 Q. And that information is provided to your  
20 auditors at the Horne group, correct?

21 A. Correct.

22 MR. SWEARINGEN: Now may I approach, Your  
23 Honor?

24 THE COURT: Yes.

25 BY MR. SWEARINGEN:

1 Q. Mr. Cagle, I'm going to hand you a document  
2 that was marked yesterday as Exhibit 7.

3 A. Okay.

4 Q. And those are interrogatory responses that  
5 your company prepared and submitted to us in response  
6 to some questions that we sent. Have you ever seen  
7 this document before?

8 A. I have not.

9 Q. Okay. If you could turn to Page 27, please.

10 A. Okay.

11 Q. And there's a question there, Number 34.

12 A. 34. Okay.

13 Q. And you'll see this is a question that we  
14 asked of SBH, and it says, "Identify the payor mix,"  
15 and then there's a parenthetical that says Medicare,  
16 Medicaid, commercial insurance, and then charity care  
17 and indigent. Do you see that?

18 A. Yes.

19 Q. And in that question we were asking your  
20 company to produce the information, including records,  
21 for how much charity care it provided. And you would  
22 agree, based on this information in the audited  
23 financials that we just looked at, that SBH maintains  
24 records of its charity care, correct?

25 A. That is correct.

1 Q. And maintains how much charity care it  
2 provides on an annualized basis, correct?

3 A. Correct.

4 Q. And if you look down at this answer, does it  
5 appear to you that any charity care number was ever  
6 provided?

7 A. The charity care would be included in the  
8 total uncompensated care.

9 Q. Okay. Which also includes bad debt, denials,  
10 and administrative adjustments, correct?

11 A. Correct.

12 MR. SWEARINGEN: That's all I have, Your  
13 Honor.

14 MR. WEST: Nothing further.

15 THE COURT: You can step down. Do not  
16 discuss your testimony or any of the exhibits in this  
17 matter with anyone else.

18 THE WITNESS: Okay.

19 THE COURT: Thank you, sir.

20 THE WITNESS: Thank you.

21 (Witness was excused.)

22 MR. WEST: Your Honor, I have a  
23 procedural point here. I discussed it -- given the  
24 events of yesterday with regard to certain documents  
25 that we received from Mountain States about the

1 patient flow sheets that were -- when I attempted to  
2 question Mr. Shaheen about them, objections were  
3 interposed and there were foundation objections  
4 raised.

5 We want to call Mr. Sullivan next, and  
6 we intend to ask him significant volumes of questions  
7 about those sheets and similar sheets that we received  
8 from Mountain States. And I discussed this briefly  
9 with Mr. Swearingen this morning because it just  
10 occurred to us last night. We have, in Ms. Bailey's  
11 deposition -- she's one of their named witnesses --

12 MR. JACKSON: Excuse me. Maybe I could  
13 short-circuit this to save us some time.

14 MR. WEST: Okay.

15 MR. JACKSON: We don't have any problem  
16 with him using the flow sheets and questioning  
17 Mr. Sullivan and, for that matter, admitting them.  
18 Ms. Bailey is going to be here tomorrow, I think, or  
19 whatever day she's going to be here, so there's no  
20 sense wasting time arguing over that.

21 MR. WEST: I appreciate that.

22 THE COURT: He's your expert, right?

23 MR. WEST: Mr. Sullivan? Yes.

24 THE COURT: I think under the rules it's  
25 the type of information that an expert relies upon.

1 MR. WEST: That's fine. We have the  
2 burden of going forward, and I wanted to make sure we  
3 use them as part of our proof.

4 MR. JACKSON: We objected yesterday  
5 because, you know, they tried to authenticate and  
6 introduce them through their own witness, and it just  
7 wasn't the right way, but I don't have any problem  
8 with them using it with Mr. Sullivan.

9 MR. WEST: All right. That being the  
10 case, we'll call Dan Sullivan next, our expert.

11 MR. JACKSON: Sorry to interrupt you.

12 MR. WEST: Oh, that's fine.

13 DANIEL J. SULLIVAN  
14 was called as a witness, and after having been first  
15 duly sworn, testified as follows:

16 DIRECT EXAMINATION

17 BY MR. WEST:

18 Q. Mr. Sullivan, could you state your name and  
19 position for the record, please, sir?

20 A. Sure. Daniel J. Sullivan, and I'm president  
21 of Sullivan Consulting Group, Inc.

22 Q. And, also, if you could state your educational  
23 background.

24 A. I have an undergraduate degree in economics  
25 and public policy studies from Duke University and a

1 master's in health administration from Duke  
2 University.

3 Q. And when did you receive your master's degree?

4 A. 1980.

5 Q. And how long has Sullivan Consulting Group  
6 been in operation?

7 A. A little over 25 years.

8 MR. WEST: And, Your Honor, I believe  
9 that we have stipulated to -- or our opponents are  
10 willing to stipulate to Mr. Sullivan's status as an  
11 expert in this field, but I wanted to go into some  
12 detail a little bit, just for the record, to establish  
13 his history.

14 THE COURT: That's fine.

15 BY MR. WEST:

16 Q. Mr. Sullivan, how long have you been involved  
17 in Certificate of Need cases where you functioned as  
18 an expert?

19 A. Since 1981. The first time I remember  
20 testifying in a case, in Florida, was in 1981.

21 Q. And roughly how many cases have you been  
22 involved in?

23 A. Many. More than a hundred.

24 Q. All right. And have you ever testified in  
25 Tennessee CON cases?

1 A. I have, I think, on maybe six or seven  
2 different occasions, maybe more than that, but over  
3 the years, going back into the late '80s through  
4 fairly recently, in the last year or so.

5 Q. And what is the most recent case you were  
6 involved in that had to do with anything related to  
7 psychiatric beds?

8 A. There was a case involving Baptist Medical  
9 Center Huntingdon, D-O-N, and they were applying to  
10 develop a small geriatric psychiatry unit. I believe  
11 that was 2013 that that project was being heard. And  
12 I testified on behalf of the applicant in that case to  
13 demonstrate that there was a need for those proposed  
14 beds.

15 Q. And was that applicant successful?

16 A. They were.

17 Q. In your work in this -- well, first of all,  
18 let me ask you. I want to ask if you can identify  
19 this document which was marked Exhibit 2 to your  
20 deposition.

21 THE COURT: Is this 2 in the notebook,  
22 Mr. West?

23 MR. WEST: I don't believe so, Your  
24 Honor. I think in some of the depositions we got out  
25 of order.

1 THE COURT: I have a notebook that says  
2 "Deposition Transcript." It wouldn't be attached to  
3 that?

4 MR. CHRISTOFFERSEN: That's not where  
5 you'll find it.

6 MR. SWEARINGEN: It's marked.

7 MR. JACKSON: We've got another number  
8 for it, I think.

9 MR. SWEARINGEN: It's Number 81.

10 MR. WEST: Number 81. All right.  
11 Previously marked as Number 81.

12 (Discussion off the record.)

13 BY MR. WEST:

14 Q. The document just laid in front of you, is  
15 this an accurate summary of your work biography,  
16 essentially, and your CV?

17 A. Yes.

18 MR. WEST: All right. Your Honor, to the  
19 extent it's necessary, I'd like to move that into the  
20 record, if I may.

21 THE COURT: Exhibit 81 is the CV of Dan  
22 Sullivan.

23 (Marked Exhibit No. 81.)

24 BY MR. WEST:

25 Q. Mr. Sullivan, in the context of your work in

1 this matter, this particular case, what steps did you  
2 take in working to -- well, first of all, what steps  
3 did you take in reaching any opinion you've reached in  
4 this matter?

5 A. Sure. I was not involved in drafting the  
6 application itself. I was engaged I think it was in  
7 January of this year after the decision had already  
8 been rendered.

9 And so my starting point was to look at  
10 the agency's file, looking at the entirety of the  
11 application and supplemental information and the  
12 transcript from the HSDA meeting where this  
13 application was considered. So that was my starting  
14 point, just to try to get a grounding in what the  
15 facts were in the case.

16 And so that led me to begin to collect  
17 information about northeastern Tennessee generally  
18 and then specifically about the service area that  
19 SBH had identified in its application.

20 I gathered information on utilization of  
21 psychiatric services, really starting broadly,  
22 looking at psychiatric hospitals across Tennessee and  
23 freestanding psychiatric hospitals across Tennessee,  
24 but then really began to focus more on the particular  
25 area where the applicant was proposing to serve and

1 looked at historical utilization that was available in  
2 a public setting.

3 At that time we were starting to get discovery  
4 information, and so I was reviewing information from  
5 both SBH and Mountain States regarding a whole variety  
6 of different things in terms of utilization and  
7 operations of the Woodridge Hospital, for example,  
8 in Johnson City, information about SBH's historical  
9 experience in operating in other markets.

10 And then I began to look at other indicators  
11 of need for psychiatric services, looking at the  
12 literature -- there's a number of different national  
13 studies and reports that I evaluated -- and looking  
14 at recent trends in terms of psychiatric utilization,  
15 availability of psychiatric services, the incidence  
16 and prevalence of mental disease in Tennessee, and  
17 specifically in northeastern Tennessee, the  
18 availability of psychiatric services and substance  
19 abuse services in the area around Kingsport where the  
20 proposed project would be located, and really began --  
21 and population data.

22 For example, I looked at what the trends were  
23 by various categories of age groups and tried to  
24 develop sort of a comprehensive picture of what was  
25 going on in that area with respect to psych services

1 and, again, to assess what the need would be.

2 And in looking at need, a starting point  
3 was looking at the Guidelines for Growth that are  
4 the -- kind of the starting point, I guess, if  
5 you will, in how you go about defining need for  
6 psychiatric services, because the State of Tennessee  
7 has adopted a methodology for projecting a need for  
8 psychiatric beds.

9 Q. And the Guidelines for Growth that you  
10 referred to, that's also sometimes called the State  
11 Health Plan?

12 A. It is.

13 Q. And did you compile a list for attachment to  
14 your report that reflected, as of the date of your  
15 report, the things you had looked at?

16 A. I did.

17 Q. Let me show you a document --

18 MR. WEST: Your Honor, I don't believe  
19 this has separately been denominated as an exhibit.  
20 If I may approach, Your Honor.

21 THE COURT: Yes.

22 BY MR. WEST:

23 Q. I'd ask if you can identify that, please, sir.

24 A. Yes. This is a summary of the documents that  
25 I -- and information that I looked at in preparing my

1 report. So that was current as of the time of my  
2 report, which was about a month or so ago.

3 Q. All right. What documents have you seen since  
4 your report?

5 A. Well, there's been a couple of more rounds  
6 of document production from Mountain States. Some of  
7 that had to do with utilization of Woodridge Hospital,  
8 financial results for Woodridge Hospital, things like  
9 deferrals of patients and things of that nature.

10 Woodridge's expert, Debbie Collier, issued a  
11 report which I certainly reviewed and analyzed. And  
12 then there was some more recent information that was  
13 available on the Mountain States website regarding  
14 how Mountain States looks at its markets and areas it  
15 serves in that eastern Tennessee region. And there's  
16 probably a few other things, but, you know, those are  
17 the main things I looked at.

18 Q. Did any of those documents you examined after  
19 your report, including Ms. Collier's report, cause you  
20 to change your opinion?

21 A. No. No. In fact, I think they tended to  
22 reinforce the basic opinions I had at the time of my  
23 report.

24 Q. And what was the basic opinion you had at the  
25 time of your report?

1 A. That the area that was identified by SBH  
2 as its service area was currently underserved for  
3 inpatient psychiatric and substance abuse services;  
4 that the existing provider that primarily served  
5 that area, Woodridge Hospital, had limited available  
6 bed capacity to address needs, particularly any growth  
7 and demand for services; that there were certainly  
8 indications that the level of utilization in counties  
9 where there weren't readily accessible psychiatric  
10 inpatient services were below what they could be if  
11 accessible services were there; and that the proposed  
12 beds that SBH set forth in its application were needed  
13 and could be reasonably well-utilized if constructed.

14 Q. And did you have any opinion as to the other  
15 criteria in the CON statute as to SBH-Kingsport?

16 A. I did. I looked at -- you know, the three  
17 main criteria deal with need, economic feasibility,  
18 and orderly development, and I looked at all three  
19 of those. And I concluded there was a need.

20 The economic feasibility, I'm not sure --  
21 there's a lot of debate about that, but it appears  
22 that this applicant is an experienced operator of  
23 psychiatric hospitals, has the resources to fund the  
24 project. And it appears that even with relatively,  
25 you know, modest projections of utilization, about 62,

1 63 percent in the second year, in the application,  
2 the project would generate in excess of revenues over  
3 expenses. So it appeared the project was economically  
4 feasible, and it was the best alternative to address  
5 the needs in the community.

6 And then, finally, with orderly development,  
7 I concluded that this project would contribute to the  
8 orderly development because it would fill a gap that  
9 existed with respect to inpatient psychiatric and  
10 substance abuse services in that part of Tennessee and  
11 it could do so with -- it would have -- undoubtedly,  
12 it would have some impact on existing providers,  
13 including Woodridge, because any time you add a new  
14 provider to a market, it's going to impact someone,  
15 but the impact would be offset by the benefits that  
16 would accrue to the community of having an accessible  
17 comprehensive psychiatric provider located in  
18 Kingsport.

19 Q. And in the process of doing your work -- well,  
20 first of all, let me back up a step.

21 In the documents you set forth in the list  
22 in front of you -- in that document I just handed you,  
23 you also have a number of publications listed that you  
24 consulted.

25 A. Yes.

1 Q. And you made many of them exhibits to your  
2 deposition.

3 A. I did. Unfortunately, there were a lot of  
4 exhibits to my deposition.

5 Q. I mean your report.

6 A. I meant my report, yeah.

7 MR. WEST: Your Honor, I'd like to make  
8 that document listing the information he reviewed an  
9 exhibit, and I don't think it's been previously  
10 numbered.

11 MR. SWEARINGEN: My suggestion would be  
12 229.

13 THE COURT: 229?

14 MR. SWEARINGEN: Yes, sir.

15 THE COURT: All right. Mr. West, are you  
16 in agreement?

17 MR. SWEARINGEN: Yes, sir, Your Honor.

18 THE COURT: Okay. We'll mark it 229.  
19 And I believe the witness identified it as a summary  
20 of documents and information that he reviewed prior to  
21 preparing his report.

22 MR. WEST: Yeah, while preparing.

23 THE COURT: Okay. While preparing his  
24 report, and it will be marked as Exhibit 229.

25 (Marked Exhibit No. 229.)

1 BY MR. WEST:

2 Q. Mr. Sullivan, you mentioned your report. When  
3 you completed your analysis and put your thoughts  
4 down, your conclusions down on paper, you did generate  
5 a report that you produced for us; is that correct?

6 A. That's correct.

7 Q. And you were examined about it at your  
8 deposition?

9 A. Yes.

10 Q. I'd like to show you a document that is marked  
11 as Exhibit 1 to your deposition, and I believe it's  
12 actually Exhibit 80 in the list of things.

13 THE COURT: Did you say 80?

14 MR. WEST: 80. Yes, sir.

15 BY MR. WEST:

16 Q. Mr. Sullivan, does this appear to be your  
17 report?

18 A. It is.

19 THE COURT: Mr. West, if you'll give me  
20 just a minute to get to that.

21 MR. WEST: I'm sorry, Your Honor.

22 THE COURT: I'm there.

23 BY MR. WEST:

24 Q. Would you describe for the record,  
25 Mr. Sullivan, the structure of this report?

1 A. Sure. There's an overview or sort of an  
2 executive summary presented in the first couple of  
3 pages of the report. I talk about the scope of what I  
4 was engaged to do and what I did. Then I go into some  
5 background concerning sort of the state of psychiatric  
6 services nationally, and then try to focus that in a  
7 bit more on Tennessee and then on the local community  
8 around Kingsport, and that's where I bring in a lot of  
9 those reports and studies that were on that list.

10 I talk about the -- Tennessee recently adopted  
11 a framework for a new comprehensive State Health Plan,  
12 and there's five principles. And I address the  
13 project's consistency with those five principles.  
14 Then I get into the first criterion, which is need,  
15 and address the Guidelines for Growth criteria under  
16 that heading, and that takes up several pages of this  
17 document.

18 And then I go over to talk about need in a  
19 more global sense. And then once I conclude on need,  
20 I look at economic feasibility, and then I go into the  
21 orderly development of health care services. So  
22 that's the basic structure.

23 Q. And you had mentioned, in describing the  
24 structure of your report, the background section that  
25 starts on Page 2. Can you, for the record in this

1 proceeding -- can you summarize that background  
2 section in terms of what you saw and what your  
3 conclusions were from that?

4 A. Sure. And I won't go into graphic detail, but  
5 the state of mental health service delivery in this  
6 country is really very fragmented. And without going  
7 too deeply into the history, back in the '70s there  
8 was a major push to deinstitutionalize patients who  
9 were locked up in state mental health hospitals, and  
10 that resulted in a number of people being returned to  
11 the community without a lot of resources really  
12 available to serve that population.

13 In the 1980s and early part of the 1990s,  
14 there was tremendous growth on the private psychiatric  
15 side of the business and that caused changes in  
16 reimbursements, changes in regulations, a number of  
17 different factors. That growth stopped and actually  
18 began to reverse, and private psychiatric hospital  
19 beds began to decline.

20 And, at the same time, the level of need in  
21 the population didn't really change very much, other  
22 than we got more people, an older population, we got  
23 more urbanization, and so we have a different set of  
24 needs. And so one report talks about the fact that  
25 about somewhere between 50 and 60 percent of the

1 people with mental illness receive no treatment at all  
2 for their problems.

3           There's significant problems with patients  
4 accessing services. Some of it has to do with lack  
5 of insurance. Some of it has to do with the lack  
6 of available resources. For example, this major  
7 deinstitutionalization that went on in the state was  
8 coupled with dramatic closures in the number of state  
9 mental health beds across the country and in  
10 Tennessee.

11           Tennessee has seen a pretty dramatic drop over  
12 the last 10 or 15 years in the number of beds and,  
13 more specifically, the state regional mental health  
14 institute that served eastern Tennessee, which was  
15 Lakeshore Mental Health Institute, closed in 2012,  
16 and so 250 beds were taken out of service in eastern  
17 Tennessee.

18           And so now the regional mental health facility  
19 that serves eastern Tennessee is in Chattanooga, which  
20 is quite a drive from the Tri-Cities area. It's over  
21 200 miles. And so you've got a gap there. That's a  
22 national problem.

23           There's studies that I cite that talk about  
24 the fact that the loss of the state mental health  
25 beds has resulted in a number of problems in terms of

1 homelessnes, increases in incarcerations, increases  
2 in deaths related to incarcerations with mentally ill  
3 people. Hospital emergency rooms are getting clogged  
4 by patients who don't have a place to go. The acute  
5 care hospitals aren't really equipped to serve them.

6 Law enforcement officials now are at the  
7 forefront of having to deal with mentally ill people  
8 either by putting them in jail or by trying to find a  
9 place they can transport them to, which in many cases  
10 involves driving them long distances to receive  
11 inpatient treatment. And so we have a very disjointed  
12 system.

13 Tennessee doesn't rank very high in a lot of  
14 measures in terms of availability of public hospitals,  
15 services, the number of beds that it currently --  
16 one study estimated they had a little bit less than  
17 10 beds per 1,000, when a target that experts have  
18 agreed on is about 50 beds per 100,000 for state  
19 mental health beds. So Tennessee has less than  
20 one-fifth of the beds that are recommended by national  
21 experts.

22 Tennessee's overall mental health system, by  
23 another study, was graded a D on a regular grading  
24 scale, and it actually slipped from a C to a D in  
25 the last few years. Tennessee has a lot of uninsured

1 individuals who have mental health problems who need  
2 treatment. And eastern Tennessee, in particular, has  
3 a problem because the number of beds there not only on  
4 the public side, which I talked about, but on the  
5 private side has declined.

6 I think there's already been some testimony  
7 about the fact that there was a hospital in Kingsport  
8 called Indian Path Pavilion. It was owned by Mountain  
9 States. And Mountain States, in 2009, applied for  
10 a CON to close that hospital. Had 61 beds. They  
11 transferred nine beds to the Woodridge Hospital and  
12 then the other 52 simply were closed.

13 And so Sullivan County, where Kingsport  
14 is located, saw a significant decrease in the  
15 availability of inpatient psychiatric beds to the  
16 point where there's only one small 12-bed unit left  
17 that's located in Bristol, which is on the -- sort of  
18 the upper right-hand side of Sullivan County, the  
19 northeastern corner, and it's only got 12 beds. It's  
20 only for adults.

21 And, as a consequence, most of the patients  
22 are having to travel outside of that area to get  
23 treatment. The largest single provider is Woodridge  
24 Hospital. I think they have a little bit more than  
25 half of the market share. The Bristol facility, the

1 Bristol Regional Medical Center, which is a Wellmont  
2 facility, has 20 percent or so of the market, and then  
3 the rest of the patients are going to various  
4 facilities in eastern Tennessee and even farther away.

5 So you have a situation where the population  
6 really has very limited access to services. You've  
7 got high need. Tennessee has high incidence of mental  
8 disease relative to other states, and so there's a  
9 need for the services. The services have been  
10 shrinking and particularly for Kingsport, which is  
11 kind of surprising that -- you know, Kingsport's the  
12 ninth largest county in Tennessee.

13 Q. You mean Sullivan?

14 A. You may have said Hawkins yesterday, but I  
15 think you meant -- Sullivan County, I meant, is -- one  
16 of us will get it right eventually.

17 So Sullivan County is the ninth largest  
18 county, but it has no freestanding psychiatric  
19 hospital and it only has 12 beds, and you compare that  
20 to other larger population centers that tend to have a  
21 higher concentration of psychiatric beds.

22 So there's -- you know, from a background  
23 standpoint, when you take sort of the 5,000-foot look  
24 at this, this is an area that's not really well-served  
25 by the existing resources, and there are community

1 resources out there.

2           Frontier Health is an organization that  
3 provides community-based services. And I'm not  
4 denigrating them in any way. I think they do a good  
5 job with what they can do, but they have limited  
6 resources.

7           And some of the studies that I cite say  
8 that while there's an effort to keep people out of  
9 hospitals, and I think we'll probably hear more about  
10 that later, that these community resources really have  
11 not filled the gap; that they have not been able to  
12 step in and fill the gap for communities, one, because  
13 some patients simply need a higher level of treatment  
14 than can be provided in an outpatient setting; and,  
15 two, they simply don't have enough dollars to go  
16 around to serve the very large population in need.  
17 So this is an area that is in need of additional  
18 resources both on the inpatient and on the outpatient  
19 side.

20 Q.           And in your report I think you address your  
21 commentary about the decline in hospital beds on  
22 Pages 3 and 4, basically?

23 A.           Yes.

24 Q.           All right. And you cite some of these studies  
25 on Pages 3 and 4 that you utilized or analyzed in

1 preparing your report?

2 A. Yes.

3 Q. And on Page 3, would you state for the record  
4 what the decline in psychiatric beds was in Tennessee  
5 from 2005 to 2010?

6 A. Sure. Just over that five-year period,  
7 Tennessee closed 462 psychiatric beds, and that was  
8 prior to the closure of Lakeshore in 2012. As I said  
9 earlier, that left Tennessee with a ratio of 9.7  
10 public psychiatric beds per 100,000, which is well  
11 below what national experts say would be the target of  
12 50 beds per 100,000.

13 Q. And what has been the -- you were asked --  
14 well, let me back up. Let me rephrase that. Did you  
15 also look at what the HSDA had done about, you know,  
16 expanding the supply of hospital beds?

17 A. Sure, I did.

18 Q. And what was that result?

19 A. There have been a number of approvals of  
20 additional psychiatric inpatient hospital beds in  
21 Tennessee over the last several years and I think  
22 in recognition of the fact that there is a need for  
23 additional comprehensive resources to serve the needs  
24 of these patients.

25 And, you know, for example, in Memphis there

1 was an approval of a new psychiatric facility and  
2 there was also bed additions approved. There were  
3 bed additions, a smaller psychiatric -- I think 25  
4 beds in Madison, Tennessee. I talked about the  
5 Baptist-Huntingdon, project.

6 There's been bed additions approved in the  
7 Nashville area, in Williamson County at Rolling Hills  
8 Hospital, and in Rutherford County at TrustPoint  
9 Hospital. And then there's been smaller, in many  
10 cases, geriatric psychiatry units approved in smaller  
11 communities throughout the state.

12 So the HSDA appears to be recognizing that  
13 there's a need to fill the void that exists and they  
14 have approved a number of additional psychiatric beds,  
15 even though the discussion nationally and locally is,  
16 you know, we need to find good community-based  
17 alternatives.

18 But you can't do everything in the  
19 community-based alternatives. You still have patients  
20 who require inpatient hospital treatment; they're  
21 severely ill, they're in crisis, they need that  
22 inpatient treatment, and then they can be transitioned  
23 back into a less intensive form of therapy. And so  
24 we have a -- I think we have an opportunity, in this  
25 case, to fill a void that exists in eastern Tennessee.

1 Q. What, if anything, would be the impact of --  
2 well, what has been the impact of crisis stabilization  
3 units in Upper East Tennessee?

4 A. Well, there is a crisis stabilization unit. I  
5 think it's in Johnson City. But, again, I think  
6 Frontier does a good job. That simply hasn't stemmed  
7 the tide, if you will, in terms of the need. There  
8 continues to be a significant problem with accessing  
9 services.

10 I think there's been some discussion already,  
11 and we'll probably get into it in a little more depth,  
12 that Woodridge has seen its utilization go up pretty  
13 significantly over the last two and a half years.

14 So these crisis stabilization units are a  
15 piece of the puzzle, but they don't eliminate the need  
16 for real inpatient psychiatric treatment.

17 Q. Have you been able to ascertain when the adult  
18 CSU in Johnson City opened?

19 A. I don't know the exact date. I'm sorry.

20 Q. Mr. Sullivan, on Page 9 of your report,  
21 you address the specific criteria, and when I say  
22 "specific," I mean under the State Health Plan, I  
23 assume, the Guidelines for Growth. Would you set  
24 forth, for the record, your analysis that is contained  
25 of the need that you analyzed?

1 A. Sure. The criterias start off with a need  
2 formula, and that's 30 beds per 100,000 population.  
3 And I think it was already mentioned in someone's  
4 opening that a critical aspect of determining need is  
5 the definition of the service area that the applicant  
6 will serve.

7 And so a starting point for my analysis was to  
8 look at what would be the appropriate service area for  
9 a 72-bed psychiatric hospital located in Kingsport,  
10 Tennessee, that would be reasonable for it to claim as  
11 its area from which it would draw a significant  
12 percentage of its patients.

13 And so there's no designation in the  
14 Guidelines for Growth as to what the service area  
15 could be. And having reviewed other psychiatric  
16 hospital applications in Tennessee, generally the HSDA  
17 has allowed the applicants to define their service  
18 area as long as they were reasonable.

19 And the service areas have all kinds of  
20 configurations. You know, they're not sort of the  
21 textbook "one county with all the counties surrounding  
22 it" being the service area. You know, it tends to  
23 look at the realities of where existing providers are  
24 located and how patients currently receive care in the  
25 community and referral patterns and things like that.

1           And so, you know, what I did is I started by  
2 looking at some actual historical data for providers  
3 who were based in Sullivan County. And maybe just to  
4 step back a little bit, I think that -- you know, I  
5 know that Mountain States wants to claim the service  
6 area is much larger and includes Washington County,  
7 Tennessee, as well as a number of other counties.  
8 And, in my view, the basis for that is they're looking  
9 at the way things are right now with the current  
10 distribution of services.

11           So the way that Woodridge defines its service  
12 area isn't necessarily going to be the way a provider  
13 located in Kingsport would define its service area,  
14 because the service area is going to depend on where  
15 you're located at, what your other interconnections  
16 are with the health care system. Right now, Woodridge  
17 has no real competition in Sullivan County or in the  
18 other counties that SBH claimed as part of its service  
19 area.

20           If you put a provider in Kingsport, that will  
21 be a different perspective. And Washington County,  
22 with an 84-bed comprehensive psychiatric hospital that  
23 is tied to one of the two large acute care health  
24 systems in eastern Tennessee, Mountain States Health  
25 Alliance, is a formidable competitor.

1           There's no reason to think that a psychiatric  
2 hospital located in Kingsport, Tennessee, would be  
3 able to draw a significant number of people from  
4 Washington County when they already have excellent  
5 access to inpatient psychiatric care, and that  
6 psychiatric hospital is part of Johnson City Medical  
7 Center, which is the largest acute care hospital in  
8 Johnson City and one of the largest in the region and,  
9 you know, in Washington County.

10           And so, you know, as a starting point, you  
11 know, I had to think about if I were -- had a blank  
12 slate and wasn't looking at the CON application, how  
13 would I draw the service area. And typically, when  
14 you have a situation like that where you have an  
15 entrenched large provider located in a community,  
16 you would tend not to think that you're going to be  
17 able to draw a lot of patients from that area.

18           But the second step was to look at other  
19 providers in Sullivan County, as well as in the  
20 surrounding areas, and how their patient origin -- by  
21 "patient origin," I just mean what percentage of their  
22 patients come from various counties.

23           And so when you look at patient origin, you  
24 generally look at -- the county you get your highest  
25 percentage of patients from is, you know, first, and

1 then the second highest and so forth.

2 And typically you want your service area --  
3 when I say "service area," I'm referring to the  
4 primary service area, and that's usually where you're  
5 going to get about 75 percent of your patients in  
6 traditional health planning.

7 Now, for certain types of tertiary services,  
8 that percentage may be a little bit lower, but for  
9 psychiatric services, somewhere around 75 percent  
10 would be a good number. And I wouldn't think, in this  
11 case, that Washington County would fall within that  
12 75 percent service area definition for a new hospital  
13 at Kingsport.

14 So then I went back and I began to look at  
15 individual hospitals in Sullivan County, and I think  
16 the first one I mentioned in here was the HealthSouth  
17 Rehabilitation Hospital.

18 Q. So you looked at other providers who were  
19 nonpsychiatric but were in Sullivan County?

20 A. That's right.

21 Q. All right. And what did you determine about  
22 HealthSouth in Sullivan County?

23 A. Well, HealthSouth is probably a good proxy for  
24 the situation we're in right now. Just a little bit  
25 of background. Inpatient comprehensive rehabilitation

1 hospitals tend to be more regionalized facilities in  
2 nature, kind of like psychiatric hospitals. It's not  
3 like a small community hospital. They tend to draw  
4 patients from a broader region.

5 But there's an interesting twist here, and  
6 that is that just like the situation that we're facing  
7 with SBH putting a psych hospital in Kingsport,  
8 there's an existing inpatient rehabilitation hospital  
9 in Johnson City. I think at one time it was owned  
10 entirely by Mountain States, and now I think it's a  
11 joint venture between HealthSouth and Mountain States.

12 And so you've got an analogous situation where  
13 you've got a specialty hospital in both places, and I  
14 think that gives you some good information about how  
15 the configuration of the service area would look for a  
16 specialty service when you have that distribution of  
17 services in the market.

18 Q. And what was HealthSouth's service area; can  
19 you recall?

20 A. Yeah. Its service area was very, very similar  
21 to the service area that SBH proposed. I think we  
22 have an exhibit that lays that out.

23 MR. JACKSON: Your Honor, before we get  
24 too far afield, I don't know if Mr. West -- I presume  
25 he's intending to tender Exhibit 80, which is the

1 report of Mr. Sullivan. I did have an objection  
2 that I would like to be heard on with respect to  
3 Exhibit 80. So before we move to another exhibit, I  
4 did want to raise that if he's intending to tender it  
5 as an exhibit.

6 MR. WEST: I do.

7 MR. JACKSON: All right. Your Honor, I  
8 don't have any objection to the report generally, but  
9 I do have an objection to Pages 19 through 23 of the  
10 report in which Mr. Sullivan has simply literally  
11 regurgitated and repeated the letters of opposition  
12 that we discussed yesterday that have been excluded  
13 from evidence -- excuse me, letters of support which  
14 have been excluded from evidence.

15 And, furthermore, when I deposed  
16 Mr. Sullivan and asked him about these letters,  
17 he agreed he's not spoken to anyone who wrote them,  
18 he's done no investigation whatsoever to determine  
19 if they're true or false. So they're not reliable  
20 information to put before the Court for the reasons I  
21 said yesterday, to put into our record which is going  
22 to -- you know, in case it goes somewhere else.

23 This is just a way to try and back door  
24 in a bunch of information which he admitted he has  
25 done absolutely nothing to verify. In one of his

1 footnotes, he admits that one of these people actually  
2 retracted their support at a later date. So this is  
3 highly unreliable material to be put in the record.

4 So what I would ask the Court to do is,  
5 if the Court is inclined to receive Exhibit 80 -- and  
6 this is our only objection to it -- is that we simply  
7 redact these pages where there's no analysis by  
8 Mr. Sullivan; it's just him dumping into his report  
9 all these third-party statements which he's done  
10 nothing to verify.

11 And he can, I guess, say he's relied on  
12 some letters, if he wants to, in his testimony, and I  
13 can cross-examine him later and establish he doesn't  
14 really know the details of any of them.

15 But I do object to allowing this  
16 back door admission of all of these letters of  
17 these third parties who could have been subpoenaed,  
18 as we had in our discussion yesterday.

19 I believe Mr. Christoffersen may want to  
20 be heard.

21 MR. WEST: Well, I think Mr. Jackson is  
22 a little overbroad in his description of this concern,  
23 because Page 23 has Dr. Elliott's letter which was  
24 admitted into evidence yesterday and he personally  
25 testified about it. But I do understand his

1 objection.

2           And I would like the opportunity,  
3 when the time comes -- I'd ask the Court to reserve  
4 judgment on it until the time comes and I address that  
5 area in my direct examination, because I want to ask  
6 Mr. Sullivan how he acquired these letters and the  
7 review he carried out, because it's my belief they're  
8 part of the HSDA's files. And if Mr. Sullivan, in the  
9 normal course of his business, reviews those files,  
10 then I believe he's got the capacity to at least  
11 mention them in his report.

12           MR. JACKSON: Your Honor, he hasn't just  
13 mentioned them; he's repeated them. I mean, he took  
14 the letters themselves and just stuck them in his  
15 report for several pages' worth of his report. It's  
16 not his own work product. It's the work product of  
17 these individuals he's never even talked to.

18           Just because he looked at them or he may  
19 look at these letters in the course of preparing his  
20 own expert opinions doesn't make them reliable  
21 evidence to be received in our proceeding.

22           MR. CHRISTOFFERSEN: Your Honor, I was  
23 just going to suggest that perhaps we should see if  
24 Mr. West can lay a foundation as to how and why this  
25 is something that an expert would reasonably rely

1 upon.

2 THE COURT: All right. I'll reserve  
3 judgment until the witness is questioned about that  
4 portion of his report.

5 MR. WEST: Thank you, Your Honor.

6 MR. JACKSON: Thank you.

7 MR. WEST: And I'll get to it fairly  
8 shortly, but I was wanting to stick with the narrative  
9 flow here for a minute, if I can remember what it was.

10 BY MR. WEST:

11 Q. Mr. Sullivan, I have to ask you, what page  
12 were you speaking about just a moment ago?

13 A. Page 10. We were talking about the  
14 HealthSouth and the exhibit that supported the text.

15 MR. WEST: All right. We have various  
16 indexes we're using in this case, Your Honor. I  
17 apologize for the delay.

18 BY MR. WEST:

19 Q. Mr. Sullivan, I'm going to hand you what was  
20 Exhibit 11 to your deposition -- to your report, but  
21 I don't believe it's previously been marked as an  
22 exhibit. Is that the document you were referring to?

23 A. Yes.

24 Q. All right. And would you describe what this  
25 document indicates and your conclusions arising

1 therefrom?

2 A. Sure. This is data taken from the joint  
3 annual report of hospitals that all hospitals in  
4 Tennessee are required to file annually with the  
5 Department of Health, and this is for HealthSouth  
6 Rehabilitation Hospital in Sullivan County.

7 And it shows that if you were defining the  
8 primary service area for this facility, it would be  
9 Sullivan and -- they didn't break out all the Virginia  
10 counties, they just said "other Virginia counties" in  
11 their report, and Hawkins County, that would represent  
12 89 percent of their total volume.

13 And you can see there's a big drop-off after  
14 those three counties in terms of the percentage of  
15 reliance that this hospital has on other counties.  
16 And so Washington County was only 3.8 percent of the  
17 total.

18 So the configuration of HealthSouth's service  
19 area is very similar. I don't know exactly which  
20 Virginia counties, but other information we'll see,  
21 I think it's likely that at least some of those  
22 counties that are included in the SBH service area  
23 would be included in that as well.

24 And so Washington County provided only  
25 3.8 percent of the total patients, despite the fact

1 that the HealthSouth facility in Kingsport is larger  
2 than the one in Washington County.

3 It's geographically very similar to SBH in  
4 terms of where SBH's facility would be located. And  
5 it's not drawing a significant number of patients out  
6 of Washington County, and also it's not drawing a  
7 significant number of patients out of many other  
8 counties that are in proximity to Sullivan.

9 And so this, I think, is probably the best  
10 example in terms of a local provider that's offering  
11 a specialty type of service in terms of what the  
12 configuration of a service area would look like.

13 And I think it speaks specifically to the  
14 objection raised by Mountain States that it would be  
15 somehow totally inappropriate, from a health planning  
16 standpoint, to leave Washington County out of the  
17 service area definition.

18 Q. And where in Washington County is that rehab  
19 hospital you mentioned?

20 A. It's located near Johnson City Medical Center.

21 MR. WEST: Your Honor, I'd like to make  
22 this the next exhibit.

23 MR. SWEARINGEN: 230.

24 THE COURT: All right. Exhibit 230 would  
25 be marked the HealthSouth Rehabilitation 2013

1 Inpatient Origin.

2 (Marked Exhibit No. 230.)

3 THE COURT: Mr. West, he has in his  
4 report references to a number of exhibits.

5 MR. WEST: Yes, Your Honor. They fill  
6 several notebooks.

7 THE COURT: But as part of his report are  
8 they -- they're going to be --

9 MR. WEST: Yes. Yes. He had two types  
10 of exhibits, some short and chart-like like this  
11 (indicating), and then he also included, for example,  
12 the Certificate of Need application for TrustPoint  
13 Hospital. We're going to make that a separate  
14 exhibit. And then he included several lengthy  
15 articles so that everyone could be familiar with them.

16 We don't intend to introduce those,  
17 except for one, because it addresses issues similar to  
18 what was served on us by Mountain States last week.  
19 So that's why you don't see just the whole report and  
20 all the exhibits coming in, because it's pretty large.

21 THE COURT: So you're not intending to  
22 attach to the report all the exhibits that are  
23 referenced in the report?

24 MR. WEST: Oh, I'm intending to introduce  
25 the report, yes, sir.

1 THE COURT: Okay.

2 MR. JACKSON: I think the answer to your  
3 question is he's not intending to introduce all of the  
4 exhibits. He's going to introduce selective exhibits.  
5 I may have objections to some exhibits. For example,  
6 I don't object to this one; I may object to some  
7 others. So I'm appreciative he's actually doing it  
8 this way. It makes it easier for me to lodge any  
9 objections I may have to the materials.

10 And he's right that the materials  
11 attached to Mr. Sullivan's report fill a very large  
12 binder. In fact, it's this binder here (indicating).  
13 These are all the exhibits. So it's a lot of stuff.  
14 So I think it's wise that he's not going to try and  
15 put them all into evidence. But if we do it one at a  
16 time, this way I can object, if appropriate, also.

17 MR. WEST: And one of the reasons we  
18 didn't include all of the publications, for example,  
19 is they're all public domain publications that are  
20 available, for example, online, that type of thing.  
21 Mr. Sullivan does address them and does cite from  
22 them, but they're available not only as exhibits but  
23 to other experts as well.

24 MR. JACKSON: And he's given a list,  
25 which has been made an exhibit, of all the materials

1 he reviewed, which is fine. I would have a problem  
2 with -- for example, there's articles and things which  
3 I don't think are properly admitted as exhibits into  
4 evidence just because an expert reviewed them, but I  
5 do think it is proper for the record to reflect what  
6 he reviewed, and it already does that because they've  
7 exhibited a list of all the materials he reviewed and  
8 they're referred to in his report as well.

9 THE COURT: Well, my question was  
10 geared -- I wanted to make sure we weren't making  
11 duplicative exhibits, because typically what's  
12 attached to an expert report comes in with the report,  
13 and so that was my concern. But I think you've  
14 addressed that, that not everything in his report  
15 you plan on attaching to the report.

16 MR. WEST: Yeah. I sort of felt like I  
17 had earned a master's degree when I got -- I'm sorry.  
18 I shouldn't make comments like that.

19 BY MR. WEST:

20 Q. Going back to your report which is in front  
21 of you, Mr. Sullivan, on Page 10, in addition to the  
22 HealthSouth information you just referenced and has  
23 been made an exhibit, what other providers did you  
24 look at that you list out on Page 10?

25 A. The next one I looked at was Indian Path

1 Medical Center, which is a Mountain States acute care  
2 facility, a little bit different character than a  
3 psychiatric hospital. It's a short-term acute care  
4 hospital.

5 But, again, I thought it would be instructive  
6 to see what its service area looked like and whether  
7 or not it was drawing a material number of patients  
8 from Washington or some of these other counties that  
9 have been alleged we should have included in the  
10 service area. And so I think I also have an exhibit  
11 showing the Indian Path Medical Center patient origin  
12 data.

13 Q. I believe you do, but at this moment I can't  
14 locate a copy. Let me go on to address that issue,  
15 though, with you. Have you seen any recent  
16 publications about the Indian Path Medical Center's  
17 service area?

18 A. I have. The Mountain States Health Alliance  
19 publishes periodically, I won't say annually -- I  
20 think it's every two or three years -- community needs  
21 health assessments. They publish those and put those  
22 on their website. And within those publications, they  
23 define what the market areas are for their individual  
24 institutions.

25 Q. Do you know the -- what other functions do the

1 community health needs assessments serve; do you know?

2 A. Well, one, I think they're supposed to educate  
3 the public, but, two, in filings with the Internal  
4 Revenue Service, not-for-profit organizations file a  
5 990 tax return. And one of the schedules to the 990  
6 tax return asks if the -- if the filer has prepared  
7 a community health needs assessment and have they  
8 identified needs of the community and have they  
9 addressed those needs.

10 Q. All right. Have you actually examined a tax  
11 return, a 990, for Mountain States?

12 A. I did.

13 Q. And how did you examine that?

14 A. It's public information. You can go on a  
15 website -- there's probably more than one way, but you  
16 can go to a website called GuideStar and pull it up,  
17 and it has the tax return and all the accompanying  
18 schedules.

19 Q. All right. Let me show you a document and ask  
20 if you can identify it.

21 MR. WEST: I will advise counsel that a  
22 non-color copy of this was named as Exhibit 211 on the  
23 list we exchanged on Friday, but because it's in  
24 color, I provided a color copy.

25 THE WITNESS: Okay.

1 BY MR. WEST:

2 Q. Mr. Sullivan, have you seen this document  
3 before?

4 A. I have.

5 Q. And what does it say and what is the date?

6 A. It says this is a 2015 community health needs  
7 assessment for Indian Path Medical Center, and it's  
8 dated June 29th, 2015, so it's pretty recent.

9 Q. And if I may ask you, can you turn to Page 4  
10 of this document?

11 A. Okay.

12 Q. There's a map on Page 4. Can you describe  
13 what that map says to you?

14 A. Sure. This divides, if you will, the areas  
15 that Mountain States serves into subregional areas.  
16 For example, it has a northeast market, a northwest  
17 market, a Washington County market, and a southeast  
18 market. And very broadly -- there's more detail in  
19 the report itself, but it sort of broadly creates  
20 circles around what these market areas look like.

21 You know, for example, the northeast market  
22 which includes Indian Path Medical Center is separate  
23 from the Washington County market which includes  
24 Johnson County Medical Center and Woodridge.

25 Q. I think you mean the northwest one.

1 A. Northwest. I'm sorry. Northwest. I  
2 misspoke.

3 Q. And so what counties are -- well, anyway, so  
4 the northwest market includes what hospitals for  
5 Mountain States?

6 A. It includes Indian Path Medical Center. It  
7 includes Norton Community Hospital and Dickenson  
8 Community Hospital.

9 Q. Those last two are in Virginia; is that  
10 correct?

11 A. That's correct.

12 Q. Can you turn to Page 31 of this document?

13 A. Sure.

14 Q. And there's a map on Page 31. What does that  
15 map appear to indicate to you?

16 A. This shows the primary service area of Indian  
17 Path Medical Center. It's the area shaded in a orange  
18 or gold color. And what it shows is that this primary  
19 service area doesn't include all of Sullivan County.  
20 It just includes western Sullivan County and includes  
21 Scott, Wise, counties in Virginia, and then Hawkins  
22 County in Tennessee.

23 So, again, this reflects, you know, a  
24 different kind of market area rather than one that  
25 would be a circular market area where you would have

1 the hospital in the middle and all of the ring  
2 counties would be part of its primary service area.

3 You can see that this is very skewed to the  
4 north and to the west, and so not even all of Sullivan  
5 County falls in there, and certainly Washington County  
6 is not included in the primary service area for Indian  
7 Path Medical Center.

8 Q. So for Indian Path Medical Center located in  
9 Kingsport and Sullivan County, Tennessee, how many  
10 Tennessee counties are in its service area?

11 A. One and a half.

12 Q. And this page also just directly lists them to  
13 the left of the map, does it not?

14 A. It does.

15 MR. WEST: Your Honor, if I may, I'd like  
16 to make this the next exhibit, and we previously  
17 indicated it would be Exhibit 211.

18 THE COURT: All right. The next exhibit  
19 marked will be 211, and it is a document published on  
20 June 29th, 2015, identified as Mountain States Health  
21 Alliance 2015 Community Health Needs Assessment,  
22 Indian Path Medical Center.

23 (Marked Exhibit No. 211.)

24 BY MR. WEST:

25 Q. You continue your analysis of these other area

1 providers on Page 11, and you speak of the Wellmont  
2 Holston Valley Medical Center.

3 A. Yes.

4 Q. And where is that located?

5 A. That's also in Kingsport. That's the largest  
6 hospital provider in Sullivan County -- or in  
7 Kingsport, I mean. I'm sorry. I'm not sure if it's  
8 bigger than Bristol Regional or not.

9 Q. And did you prepare an exhibit on this?

10 A. I did.

11 Q. I'm going to tender this exhibit to you.  
12 And what is this document I just handed to you,  
13 Mr. Sullivan?

14 A. This is 2013 patient origin data taken from  
15 the joint annual hospital report for Wellmont Holston  
16 Valley Medical Center located in Kingsport.

17 Q. And looking at this, what is your  
18 understanding of -- what use did you make of these  
19 data?

20 A. Well, I looked at it, again, to look at what  
21 I would define as the primary service area for this  
22 hospital. And, again, I'm trying to get the area  
23 that encompasses 75, 80 percent of the total patient  
24 population that they serve.

25 And we can see that Sullivan and Hawkins are

1 the two largest, other Virginia counties that weren't  
2 separately identified, and then Scott and Wise which  
3 were identified. Washington County comes in in sixth  
4 place, and so I would see Washington County as part of  
5 the secondary service area of Holston Valley Medical  
6 Center. The primary service area would be Sullivan  
7 and Hawkins in Tennessee and then various Virginia  
8 counties.

9 Q. And so what is -- for Washington County, for  
10 Wellmont Holston Valley Medical Center, what is the  
11 percentage of its total discharges that come from  
12 Washington County, Tennessee?

13 A. It's 5.7 percent, so it's not a major presence  
14 in Washington County.

15 Q. And there's also a Washington County,  
16 Virginia, isn't there?

17 A. There is.

18 Q. I don't believe it's on here.

19 A. This was all cut and pasted from the joint  
20 annual report, so it may be in another category.

21 MR. WEST: Your Honor, I'd like to make  
22 this the next exhibit, if I may.

23 THE COURT: What number is that?

24 MR. SWEARINGEN: 231.

25 MR. CHRISTOFFERSEN: May I interject for

1 a moment? I know you're on a roll, though, and I  
2 don't want to interrupt on your progress or flow, but  
3 if this is a point where we could take a five-minute  
4 break, I would appreciate it.

5 THE COURT: Let me identify this exhibit  
6 and then we'll do that.

7 Exhibit 231 will be marked as Wellmont  
8 Holston Valley Medical Center 2013 Inpatient Origin.

9 (Marked Exhibit No. 231.)

10 THE COURT: We'll go ahead and take a  
11 short break.

12 (Recess observed.)

13 BY MR. WEST:

14 Q. Mr. Sullivan, I want to continue with your  
15 description on this of your service area analysis.  
16 You also looked at data, according to Page 11 of your  
17 report, concerning Wellmont Bristol Regional Medical  
18 Center Psychiatric and Substance Abuse.

19 A. I did.

20 Q. And what was your conclusion from looking at  
21 those data?

22 A. Again, that -- Bristol Regional has a much  
23 different patient origin pattern than the other  
24 hospitals in Sullivan County, and not surprising,  
25 because they're located right on the Virginia border,

1 and I think part of their campus is actually in  
2 Virginia.

3 So they draw very heavily from Washington  
4 County, Virginia -- I think that's their number one  
5 county -- to a lesser extent from Sullivan County, and  
6 virtually no patients come from Washington County,  
7 Tennessee.

8 Q. And did you summarize your analysis in  
9 Exhibit 14 to your report?

10 A. Yes.

11 Q. I'd like to show you that document, if I may.  
12 Is this your analysis of the Wellmont -- I always  
13 called it BRMC, Bristol Regional Medical Center --

14 A. Yes.

15 Q. -- data you're speaking of?

16 A. And this is specifically -- I should have  
17 said specifically for psychiatric and substance  
18 abuse discharges. And this came, actually, from some  
19 information Mountain States had provided in discovery,  
20 because I don't have access to the detailed patient  
21 origin data from the Tennessee Hospital Association  
22 database.

23 And what it shows is that this Bristol  
24 Regional psych facility is really more oriented  
25 towards Virginia than it is towards Tennessee, where

1 a little over -- about 22 percent of its patients came  
2 from Sullivan County, Tennessee.

3 But if you look at all of the counties after  
4 that, they're all Virginia counties until you get all  
5 the way down to Hawkins, which is a very small  
6 percentage, and Washington, Tennessee, which is a very  
7 small percentage and negligible amounts.

8 And so there are sort of two takeaways from  
9 this. I think one is that even though this is located  
10 in Sullivan County, it doesn't serve Washington  
11 County, Tennessee, to any great extent; and, two, the  
12 Wellmont Bristol Regional psychiatric unit is really  
13 focused more on serving Virginia residents than they  
14 are serving Tennessee residents. And so to the extent  
15 those beds are available, they're not being accessed  
16 to a great extent by residents of Sullivan County and  
17 some of the surrounding counties.

18 Q. Were you able to ascertain whether this  
19 concerned just the 12 beds in Sullivan County, or did  
20 it also concern the other Bristol beds?

21 A. My understanding is this was just the 12 beds  
22 at Bristol Regional. There's a separate facility in  
23 Washington County, Virginia, called Ridgeview, I  
24 believe.

25 Q. And is that also owned by Wellmont?

1 A. It is.

2 Q. And the source of this document -- the source  
3 of these numbers that you set forth is a Mountain  
4 States document produced in discovery, Number 792?

5 A. Yes.

6 MR. WEST: Your Honor, if I may, I'd like  
7 to make this the next exhibit.

8 THE COURT: What's the exhibit number?

9 MR. SWEARINGEN: 232.

10 THE COURT: Exhibit 232 will be marked  
11 Wellmont Bristol Regional Medical Center Psychiatric  
12 and Substance Abuse Discharges by County.

13 (Marked Exhibit No. 232.)

14 BY MR. WEST:

15 Q. Mr. Sullivan, if I may, I want to ask you,  
16 in the course of examining community health needs  
17 assessments generated by Mountain States Health  
18 Alliance facilities, did you also examine one for  
19 Johnson City Medical Center?

20 A. Yes.

21 Q. And I want to show you a document, if I may.  
22 It's not -- it will be -- let's see. It would be  
23 Exhibit 212. It's not previously been marked, but  
24 it's listed. This is the color version.

25 Mr. Sullivan, I've just handed you this

1 document. Would you read the front page again just  
2 briefly?

3 A. Sure. It's 2015 Community Health Needs  
4 Assessment, Johnson City Medical Center dated  
5 June 29th, 2015.

6 Q. Does it follow the same format, basically, to  
7 your eyes, as the Indian Path Medical Center one we  
8 just looked at a moment ago?

9 A. Yes.

10 Q. And on Page 4 does it have the same market  
11 circles on it?

12 A. It does.

13 Q. I'm going to ask you to look at what, I  
14 believe, is Page 31.

15 A. Okay.

16 Q. And Page 31, what information does that map or  
17 that page disclose to you?

18 A. This looks at what the primary service area is  
19 for Johnson City Medical Center.

20 Q. All right. And it also lists the counties; is  
21 that correct?

22 A. It does.

23 Q. And does it include Hawkins County, Tennessee,  
24 in its service area?

25 A. It does not.

1 Q. Does it include any Virginia counties in its  
2 service area?

3 A. It does not.

4 MR. WEST: Your Honor, this has been  
5 designated Exhibit 212. I'd like to move it into  
6 evidence, if I may.

7 THE COURT: Exhibit 212 will be marked as  
8 Mountain States Health Alliance 2015 Community Health  
9 Needs Assessment, Johnson City Medical Center.

10 (Marked Exhibit No. 212.)

11 BY MR. WEST:

12 Q. Mr. Sullivan, I'd like to go ahead and return  
13 to your report and ask you what the next information  
14 you discussed in your report after the analysis of  
15 Wellmont BRMC's psychiatric services was.

16 A. I wanted to look specifically at the issue  
17 that Mountain States had alleged, that it would be  
18 unreasonable to exclude a contiguous county like  
19 Washington from -- Washington County, Tennessee, from  
20 the service area.

21 So I was familiar that TrustPoint Hospital  
22 that's located in Rutherford County had recently  
23 received approval for additional psychiatric bed  
24 capacity, and so I reviewed that application to look  
25 at how TrustPoint had defined its service area.

1 Q. And what did you learn from that?

2 A. That TrustPoint defined its service area to  
3 be Rutherford and Bedford counties. That's despite  
4 the fact that Rutherford adjoins Williamson County,  
5 Davidson County. Davidson County was the second  
6 largest source of patients to TrustPoint Hospital  
7 based on the patient origin information they provided  
8 in the application.

9 But their argument was that the area they  
10 were really focused on serving was the two-county  
11 area, being Rutherford and Bedford counties, and the  
12 HSDA accepted that service area definition.

13 Q. And where are there -- in relation to  
14 Rutherford County, where are the nearest psychiatric  
15 hospital providers?

16 A. Well, they're really all around Rutherford  
17 County, but certainly Williamson County has a  
18 relatively large psychiatric provider called Rolling  
19 Hills. Then there are a number of large psychiatric  
20 providers in Davidson County, including Vanderbilt  
21 and Centennial Medical Center, and a number of other  
22 smaller providers. Then some of the counties on other  
23 sides of Rutherford County also have smaller units.

24 And so what the applicant was describing, and  
25 what I was trying to describe earlier in this, is when

1 you define a service area, you don't define it from  
2 the service area of somebody else.

3 For example, Vanderbilt serves Rutherford  
4 County, Centennial serves Rutherford County, but that  
5 doesn't mean that a facility in Rutherford County's  
6 service area is going to look like Vanderbilt and  
7 Centennial. And so I think this is a good example.

8 And, you know, just to sort of take the  
9 analysis one step further, Rolling Hills had  
10 previously applied for additional psychiatric beds,  
11 and they're in Williamson County, and they had claimed  
12 Rutherford County as part of its service area, but  
13 still, the HSDA did not consider the Rolling Hills  
14 facility in evaluating the need that TrustPoint had  
15 set forth in the application.

16 Q. And was Rolling Hills also approved for their  
17 expansion?

18 A. They were.

19 Q. And so you had testified earlier about the  
20 HSDA's recognition, in your view, of the need for  
21 additional beds. Are these examples of that?

22 A. They are.

23 Q. And how recent was the TrustPoint decision?

24 A. The TrustPoint decision was, I think, late  
25 last year, and then the Rolling Hills one was, I

1 think, in 2013.

2 Q. So those are relatively recent decisions?

3 A. Yes.

4 Q. Taking all these factors into account -- well,  
5 let me ask you. What was the next step in your  
6 analytic process described in your report?

7 A. Well, I guess the next step was that I  
8 concluded that the service area that SBH had proposed  
9 was reasonable, and then I proceeded to evaluate the  
10 bed need in that county using the Guidelines for  
11 Growth formula.

12 So the next step was to look at the population  
13 in that area, and that starts at the bottom of Page 11  
14 and goes over to the top of Page 12. And without  
15 belaboring it, it's a relatively populous area. It's a  
16 little over 300,000 people. It's going to grow by a  
17 small amount between 2014 and 2019.

18 Even though two of the counties are in  
19 Tennessee and three are in Virginia, 71 percent of  
20 the population is in the two Tennessee counties. So  
21 this is a project primarily serving Tennessee state  
22 residents. And so I used that population as a basis  
23 for projecting need for additional beds.

24 Q. And would you walk through that process step  
25 by step for the record?

1 A. Sure. Again, the formula is 30 beds per  
2 100,000. And the first step is to apply that to  
3 the total population. It's pretty simple math.  
4 You multiply 30 times the population, divide it by  
5 100,000, and that tells you the gross number of beds  
6 that are needed to serve -- psychiatric beds that are  
7 needed to serve that population.

8 In this case, if you do that analysis using  
9 2015 population data, the current year, you come up  
10 with a need for 92 beds. If you use 2020 population,  
11 you come up with a need for 93 beds. So there's not a  
12 lot of difference from current and projected bed need.

13 And within the service area, there's a single  
14 psychiatric provider, and that's Wellmont Bristol  
15 Regional Medical Center, that has 12 beds. So if  
16 you subtract the 12 beds from the 92 or 93 that are  
17 needed, you get a need for 81 or 82 beds. So looking  
18 at it broadly from the standpoint of the Guidelines  
19 for Growth formula, the 72 beds proposed by SBH is  
20 consistent with the overall need for beds in that  
21 area.

22 Q. And in taking these steps, you analyzed this  
23 data county by county; is that correct?

24 A. I did.

25 Q. In terms of the population?

1 A. I did.

2 Q. And you prepared an exhibit to your report to  
3 that effect?

4 A. I did.

5 MR. WEST: All right. If I may, Your  
6 Honor, I'd like to show Mr. Sullivan this report.

7 BY MR. WEST:

8 Q. I believe it's Exhibit 17 to your report.

9 A. Yes.

10 Q. And can you describe what that is, please?

11 A. Sure. This is just the baseline population  
12 data that I used, and it shows for each individual  
13 county the breakdown of population by three age  
14 groups: under 18, 18 to 64, and 65 and older. And  
15 it looks at it from -- looks at 2013, 2015, 2019.

16 MR. WEST: Your Honor, I'd like to make  
17 this document the next exhibit. I believe it will be  
18 233, but I'll defer to Mr. Swearingen.

19 MR. SWEARINGEN: I think that's correct,  
20 Your Honor.

21 THE COURT: 233?

22 MR. WEST: Yes. Yes, sir.

23 THE COURT: All right. Exhibit 233 will  
24 be marked as the Historical and Projected Service Area  
25 Population.

1 (Marked Exhibit No. 233.)

2 BY MR. WEST:

3 Q. Mr. Sullivan, in your report -- or as an  
4 exhibit to your report, did you also prepare a table  
5 or an exhibit listing out bed-need calculations?

6 A. I did.

7 Q. For this service area?

8 A. I did.

9 Q. All right. I'd like to show you what is  
10 your -- I believe your report's Exhibit 18 and ask if  
11 you can identify that, please, sir.

12 A. Yes. This is what I just described, the  
13 projected bed need for the service area population as  
14 a whole that results in a net need for 80 or 81 beds,  
15 depending upon which year you're looking at.

16 MR. WEST: Your Honor, I'd like to move  
17 this document into evidence. I believe it would be  
18 Exhibit 234.

19 MR. SWEARINGEN: Yes, sir.

20 THE COURT: Exhibit 234 will be marked  
21 Total Psychiatric Bed Need Under Guidelines for Growth  
22 Formula.

23 (Marked Exhibit No. 234.)

24 BY MR. WEST:

25 Q. Mr. Sullivan, would you take us to the next

1 step in your analysis set forth in your report and  
2 what you did?

3 A. Sure. The guidelines then ask you to break  
4 the population down into some age segments and look at  
5 the need for specific age groups in the population.  
6 So the first thing I looked at was the need for the  
7 population over 18.

8 And what I did is I actually broke that  
9 into two pieces, because SBH was proposing to have  
10 both adult beds and geropsychiatric beds, which  
11 are primarily for older patients. I looked at the  
12 population 18 to 64, and then I separately looked at  
13 the population 65 and older.

14 Q. And did you set forth your 18 to 64 population  
15 analysis in an exhibit to your report?

16 A. I did.

17 Q. I want to show you a document that I believe  
18 is that document.

19 Can you identify this document I just handed  
20 to you, Mr. Sullivan?

21 A. Sure. This is a calculation that I performed  
22 that looked at the population age 18 to 64 and  
23 calculated the need in 2015 and 2019. And the total  
24 need or the gross need was either 56 or 57 beds,  
25 depending on which year you were looking at.

1           The Wellmont beds, the Wellmont Bristol  
2 Regional beds are all in the adult category, so I  
3 subtracted the 12 beds at that facility from the  
4 projected need and came up with a net need of 44 to 45  
5 beds, again, depending on which year.

6           And SBH is proposing to have an 18-bed adult  
7 psychiatric unit and they're also proposing a 10-bed  
8 adult chemical dependency unit. And there's not a  
9 separate methodology for chemical dependency beds,  
10 so I included the 10 beds for the adult chemical  
11 dependency with the adult psychiatric, which total 28.  
12 And you can see that the 28 beds proposed are, you  
13 know, well less than the needed number of beds of 44  
14 or 45.

15 Q.       So even if SBH were to build this project in  
16 2015, this analysis would show, for example -- what  
17 would this analysis show as the net remaining need, if  
18 any?

19 A.       It would show a need for an additional 16 or  
20 17 adult beds in the area.

21           MR. WEST: Your Honor, I'd like to make  
22 this the next exhibit. I think it's 235.

23           THE COURT: Exhibit 235 will be marked  
24 Adult Psychiatric Bed Need Under the Guidelines for  
25 Growth Formula.

(Marked Exhibit No. 235.)

BY MR. WEST:

Q. All right. Mr. Sullivan, you performed similar analyses both for the over 65 age group population and, I believe, under 17?

A. Under 18.

Q. Under 18?

A. Yes.

Q. Okay. What were your conclusions about the over 65 -- 64 -- 65-and-over population?

A. I don't think I actually cite that in my report, but there was also projected need for the 65 and older population for the beds that were proposed.

Q. And did you also do so for, I think it's the 17-and-under population?

A. Yeah, I did.

Q. All right. Let me show you a document that was attached as, I believe, Exhibit 20 to your report and ask if you can identify it.

A. Yes. This is a calculation for the service area of the child and adolescent bed need using the population under age 18. And, again, I'm just applying the 30 beds per 1,000 to the total population under the age of 18.

Q. You mean 30 beds per 100,000?

1 A. Per 100,000. Be a lot more need. In this  
2 case, it showed a need for 17 beds in 2015 and 15 beds  
3 in 2019. And in this case SBH is proposing 28 beds.

4 So this was in a case where, looking at the  
5 subgroup, the number of beds needed was not exactly on  
6 point with the 30 beds per 1,000 [sic] guideline.

7 Q. What impact does this analysis have on your  
8 conclusions that you listed earlier about whether this  
9 project satisfies the criteria?

10 A. Well, first of all, and I mentioned this  
11 earlier in my report, you know, the guidelines are  
12 that, they're guidelines. They're not hard-and-fast  
13 standards that have to be met.

14 When you look at the broader landscape in  
15 East Tennessee, there are very few beds for child and  
16 adolescent patients in that market. Woodridge has a  
17 12-bed unit, and I think you have to go, I believe, to  
18 Nashville before you hit another one heading west or  
19 go down to Chattanooga, you know, heading south or go  
20 into Virginia, in the other direction, to find child  
21 and adolescent beds.

22 And so this was an area where I would expect  
23 there to be more in-migration from outside the service  
24 area for child and adolescent patients just because  
25 there aren't very many resources in the area for child

1 and adolescent patients.

2 And this -- I don't want to get into --  
3 there was testimony at the HSDA meeting regarding the  
4 specific need for child and adolescent beds, which I  
5 reviewed, and the relative scarcity of those beds.

6 And I think Ms. Bailey, who is the director  
7 of the Woodridge unit, I think, even spoke at the  
8 HSDA meeting about the fact that there were very  
9 limited resources on a statewide basis for child and  
10 adolescents and patients were sometimes being shipped  
11 long distances to receive treatment.

12 And so even though this wasn't perfectly  
13 consistent with the 30-bed-per-thousand standard, I  
14 don't think the 30 beds, you would expect it to apply  
15 equally to every age group in the population. That  
16 would be very unusual. And I think you have to take  
17 into account the, sort of, availability.

18 For example, there are many other psych  
19 units outside of our service area where you would  
20 expect there to be less in-migration for the adult  
21 psychiatric patients, but on the child and adolescent,  
22 I think it's prudent to have additional capacity to be  
23 able to meet that need.

24 Q. Can you identify any other child and  
25 adolescent -- child or adolescent inpatient

1 psychiatric unit anywhere in the Johnson City Medical  
2 Center area or anywhere in the Indian Path Medical  
3 Center service area other than the 12 beds at  
4 Woodridge?

5 A. I cannot.

6 Q. And have you seen any reports indicating there  
7 are any such units?

8 A. Everything I've looked at has indicated there  
9 are not such units.

10 MR. WEST: All right. If I have not  
11 already done so, Your Honor, I would like to make this  
12 the next exhibit. It will be 236, I believe.

13 THE COURT: Exhibit 236 will be marked as  
14 the Child/Adolescent Psychiatric Bed Need Under the  
15 Guidelines for Growth Formula.

16 (Marked Exhibit No. 236.)

17 BY MR. WEST:

18 Q. Now, Mr. Sullivan, did you also analyze, in  
19 the context of preparing your report, the utilization  
20 levels of the Wellmont Bristol Regional Medical Center  
21 with the 12 beds?

22 A. I did.

23 Q. All right. And for the record, when you speak  
24 of occupancy percentage, for example, how do you  
25 calculate that?

1 A. Well, you take the total number of patient  
2 days, the number of days that a patient occupied a bed  
3 in the facility, you divide that by the number of days  
4 in a year, and that gives you what's called average  
5 daily census. So it tells you on average how many  
6 people were occupying a bed on any given day. And  
7 then you divide that average daily census by the total  
8 number of beds, and that tells you what the average  
9 occupancy rate was during the year.

10 So, obviously, occupancy varies during the  
11 week and times of day and so forth, but that's a  
12 pretty basic health planning statistic that you look  
13 at in terms of measuring utilization of a hospital's  
14 bed capacity.

15 Q. And is it fair to say that that analysis is a  
16 measure of the availability of beds or availability of  
17 services or beds?

18 A. It certainly is, yes.

19 Q. All right. Mr. Sullivan, I'm going to show  
20 you a document, which I believe is Exhibit 21 to your  
21 report, and ask if you can identify that, please, sir.

22 A. Sure. This is data taken from the Wellmont  
23 Bristol Regional joint annual report of hospitals. It  
24 looks at three years. And you can see the utilization  
25 has been going up a bit, you know, over this period

1 of time. And its occupancy rate was close to  
2 66 percent in 2013, so about two-thirds of its beds  
3 were occupied, which means that on average there were  
4 four vacant beds at Bristol Regional.

5 Q. In 2013?

6 A. In 2013.

7 Q. And have you been able to access the 2014  
8 joint annual reports?

9 A. Not yet.

10 MR. WEST: Your Honor, I'd like to make  
11 this the next exhibit, if I may. 237.

12 THE COURT: Exhibit 237 will be marked  
13 Wellmont Bristol Regional Medical Center Psychiatric  
14 Bed Utilization.

15 (Marked Exhibit No. 237.)

16 BY MR. WEST:

17 Q. Mr. Sullivan, without referencing any  
18 testimony of the hearing or any letters, what were the  
19 next steps in your report or the next processes you  
20 went through after these that have been described in  
21 these exhibits?

22 A. Well, once I'd gotten through the bed-need  
23 methodology and concluded that the project was  
24 consistent with the guidelines related specifically  
25 to the quantitative need for beds, then I looked at

1 the other criteria that are contained within the  
2 Guidelines for Growth. And some of these are a bit  
3 redundant, so I can -- do you want me to just kind of  
4 walk through these fairly quickly?

5 Q. Yeah, you can do that. Just do it briefly.  
6 Yes, sir.

7 A. For example, on Page 13, Number 4 says, "The  
8 total need should be adjusted by the extent staff beds  
9 operating in the area are counted by the Department of  
10 Health in the joint annual report." I did that on my  
11 calculations we just looked at.

12 And then it says, "The geographic service area  
13 should be reasonable and based on an optimal balance  
14 between population density and service proximity or  
15 the community service agency."

16 And I do think, based on all the foregoing  
17 discussion, that the way the service area was defined  
18 does balance population density. There's over  
19 300,000 people in this area. Sullivan County's a  
20 large county.

21 And service proximity, there really are  
22 very limited services available right within that  
23 community. And so I think the service area was  
24 reasonably defined in this case.

25 Q. And in carrying out that -- in reaching that

1 conclusion, did you also look back to these other  
2 analyses of Indian Path's service area and so forth?

3 A. I did. I looked at all of that as well as  
4 those prior decisions regarding psychiatric services  
5 in Tennessee.

6 Q. I wanted to ask you also, you reviewed the  
7 TrustPoint Hospital CON application --

8 A. I did.

9 Q. -- as part of your analysis?

10 In your recollection, what did -- how did  
11 TrustPoint fulfill all the elements of the different  
12 population groupings for bed need analysis?

13 A. Well, there was also an issue, I think, in the  
14 TrustPoint application where I believe it was child  
15 and adolescent beds weren't perfectly consistent with  
16 the 30-beds-per-1,000 standard, but I think they  
17 provided additional information that said that there  
18 was a particular need for those types of services in  
19 the community.

20 Q. All right. I think you said 30 beds per  
21 1,000 --

22 A. I'm sorry. Per 100,000.

23 Q. And will you continue down your analysis on  
24 Page 14, please, sir?

25 A. Sure. Number 2 at the top of Page 14 talks

1 about socio-demographics, projected population, and  
2 accessibility of consumers, particularly women, racial  
3 and ethnic minorities, low-income groups, and those  
4 needing services involuntarily.

5 SBH is providing a comprehensive proposal  
6 for a new facility. They're really planning to serve  
7 all of the age groups in the population. They're  
8 going to take involuntary commitments, and from the  
9 representations made in their application, they're  
10 going to serve all ethnic groups. They're going to  
11 provide around 5 percent charity care for low-income  
12 residents.

13 And I heard Mr. Shaheen say that they  
14 were also willing to participate with the state  
15 in contracting for those patients who previously had  
16 gone to Lakeshore, so I believe the application would  
17 provide an appropriate level of access for all these  
18 different groups.

19 "Relationship to the existing applicable  
20 plans," I didn't really find any applicable plans that  
21 addressed the need for psychiatric services in that  
22 area.

23 And then the next one was "Relationship  
24 to underserved geographic areas and underserved  
25 population groups identified in state, county or

1 regional plans." I didn't see any such state, county,  
2 or regional plans.

3 Q. What about the Guidelines for Growth?

4 A. Well, the Guidelines for Growth, and I  
5 addressed that already. And then "Impact of the  
6 proposal on similar services supported by state  
7 appropriations should be assessed and considered," the  
8 way I read this, you know, state appropriations, I  
9 think, refer to the regional mental health institutes,  
10 and since there's not one in East Tennessee and the  
11 designated one is in Chattanooga, I couldn't envision  
12 this project really having any material impact on  
13 Moccasin Bend Medical Center in Chattanooga.

14 And Woodridge, to the extent that -- they  
15 don't receive appropriations, but they do receive  
16 grant money from the Tennessee Department of Mental  
17 Health and Substance Abuse Services. And as I  
18 mentioned just a minute ago, SBH is willing to  
19 participate in that same process.

20 And so I don't believe that Woodridge falls  
21 under this category of this particular criteria. But  
22 to the extent that someone wants to talk about that, I  
23 believe that this project will provide a complement to  
24 what Woodridge is doing in trying to serve that  
25 unfunded patient population.

1 Q. Do you know, sitting here today, whether the  
2 contract for the -- the grant contract, we call it,  
3 between the Department of Mental Health and Substance  
4 Abuse Services that you referenced, who the department  
5 is contracting with? Is it contracting directly with  
6 Woodridge, or do you know?

7 A. I believe, on the documents I saw, they're  
8 contracting with Mountain States Health Alliance.

9 Q. So if you were to evaluate services supported  
10 by state appropriations, if it was applicable outside  
11 of the mental health institutions, you would have to  
12 look to Mountain States, wouldn't you? It would  
13 impact on Mountain States?

14 A. Yes. Yes. And I'll talk more about impact  
15 later in the report.

16 Q. Okay. So on Page 15, can you proceed with  
17 your analysis?

18 A. Sure. "4: Whether the facility takes  
19 voluntary and/or involuntary admissions, and whether  
20 the facility serves acute and/or long-term patients  
21 should be discussed and considered."

22 The SBH will take voluntary and involuntary.  
23 They won't be serving the long-term patient care  
24 population because the length of stay is approximately  
25 10 days. I think the testimony is 9.2 days is the

1 most current experience for the Woodridge facility.

2 Q. And what's the next criterion to address?

3 A. The degree of financial participation in the  
4 Medicare and TennCare programs. And Woodridge -- I'm  
5 sorry, SBH proposes 38 percent of its revenues will  
6 come from TennCare patients and 27 percent from  
7 Medicare, and that's somewhat a function of the mix of  
8 beds that are being proposed. So they are providing  
9 access to those two payor groups.

10 And then the next section deals with  
11 "Relationship to existing similar services in the  
12 area." And the area's trends in occupancy and  
13 utilization of similar services should be considered.  
14 We've already talked about the Wellmont Bristol  
15 Regional, which is the only hospital providing  
16 psychiatric services in the service area for SBH.

17 I do discuss here that the utilization at  
18 Woodridge, even though it's not in the service area,  
19 it is the largest single provider of services to  
20 the service area, and talk about the fact that  
21 historically they didn't have a high level of  
22 utilization.

23 But we learned through deposition testimony  
24 that in late 2013, Mountain States undertook what  
25 they called a value stream analysis. They were

1 particularly looking at ways to improve access  
2 to the beds at Woodridge because patients were  
3 languishing in emergency departments waiting for  
4 placement in a psychiatric bed.

5           And I think the particular focus of this value  
6 stream analysis was Indian Path Medical Center in  
7 Sullivan County. And they identified a number of gaps  
8 with respect to behavioral health services that were  
9 being provided primarily at Woodridge. That's  
10 summarized on Page 16.

11           And the first one, which I thought was  
12 interesting, was that patients are being held greater  
13 than 24 hours in the emergency department, and that's  
14 because -- for two reasons they cited: adult acute  
15 care beds, there's not enough of those because the  
16 doctors are not discharging early enough; and also  
17 the closure of the state hospital which increased the  
18 census at Woodridge.

19           And that's somewhat contrary to what Woodridge  
20 stated at the HSDA meeting back in June of 2014 where  
21 they said that, you know, they have plenty of capacity  
22 and that the contract with the state really wasn't an  
23 issue in constraining their capacity.

24           There's a number of other things that were  
25 identified in here in terms of changes that needed to

1 be made. The last one I thought was also significant,  
2 is that the lack of medical community knowledge of all  
3 of Woodridge's services and that Mountain States did  
4 not seem to value marketing the services.

5 Q. What documents have you seen concerning  
6 utilization at Woodridge since the completion of your  
7 service area report?

8 A. There's been a few different documents.  
9 There's been some that show monthly utilization, and  
10 then there's some that show utilization for, for  
11 example, fiscal year 2014, 11 months of fiscal year  
12 2015, then some individual months as well in there.

13 Q. Have you seen the patient flow sheets, for  
14 example?

15 A. I have. Yeah. That's a more on-the-ground  
16 look at what the utilization is.

17 Q. What has been the impact, if any, of those  
18 documents on your conclusions set forth on Page 16,  
19 for example?

20 A. That Woodridge, as they began to address what  
21 I'll term structural issues as opposed to, you know,  
22 lack of need for patients to be served, the fact that  
23 there were barriers, if you will, to patients getting  
24 in and out of the hospital relatively expeditiously,  
25 and so as Woodridge began to address some of those

1 things, I think one of the things they did -- I think  
2 Ms. Bailey testified -- is they changed the medical  
3 direction of their unit.

4 It was previously under the direction of  
5 East Tennessee State University physicians, and they  
6 brought in the Mountain States Medical Group, a group  
7 of physicians that they employ, and they were able to  
8 streamline processes. They were able to get patients  
9 in and out faster and apparently have increased the  
10 awareness of these services, and as a result the  
11 utilization has grown pretty significantly.

12 I think as late as 2011 the occupancy rate was  
13 only 56 and a half percent, and by the end of 2015, it  
14 was running close to 90 percent occupancy. So there's  
15 been a pretty dramatic change. And it didn't have  
16 anything to -- I mean, more people didn't move into  
17 the area. It was just some of the artificial  
18 constraints on the use of the beds were corrected and  
19 the beds filled up.

20 Q. When you say the end of '15, you're talking  
21 about their fiscal year, not --

22 A. I meant fiscal year. I'm sorry. I mean  
23 fiscal year, which ends in June 2015.

24 MR. WEST: Your Honor, may I approach the  
25 witness and draw on an exhibit previously marked?

1 THE COURT: Yes.

2 BY MR. WEST:

3 Q. Let me show you, Mr. Sullivan, an exhibit  
4 that's been marked for identification and ask if you  
5 can identify it, please, sir.

6 A. Yes. These are daily patient flow sheets for  
7 Woodridge Hospital starting back in January of 2015.  
8 And I think there are a few days that are missing in  
9 here, but, generally, I think they cover the period up  
10 to the end of June 2015.

11 Q. So those are the flow sheets, they call them,  
12 for the first six months of 2015?

13 A. That's correct.

14 Q. And did you analyze those?

15 A. I did.

16 Q. And what kind of analysis did you perform?

17 A. Well, it was -- it was pretty straightforward.  
18 The flow sheets show the census, which is how many  
19 people are actually occupying a bed at that time on  
20 that day -- I think they were taken around 7:30 or  
21 8:00 in the morning, is when this sheet was filled out  
22 -- how many blocked rooms there are.

23 And I understand from Ms. Bailey's deposition  
24 that a blocked room means that when you have a double  
25 occupancy -- or I think they even have a room that has

1 four beds in it -- that you can't get another patient  
2 in there because one patient's aggressive and -- or  
3 it may be a gender issue -- you know, you can't put a  
4 male in with a female -- might be an infection issue.  
5 I mean, there's a number of different reasons why you  
6 would have to block a room. And so that would be a  
7 room that would be taken out of service and not  
8 available on that day.

9           And then it had the remaining beds  
10 available -- after looking at the total number of  
11 beds that are available in each of these units, the  
12 number of patients occupying beds, the number of  
13 blocked beds, the remainder would be the beds  
14 available on any given day.

15 Q.       Does it also show information as to patients  
16 waiting to get in?

17 A.       It does. At the bottom of the sheet, it has a  
18 listing of the number of patients waiting for a bed on  
19 a particular day.

20 Q.       And did Ms. Bailey review earlier versions of  
21 these flow sheets in her deposition?

22 A.       She did.

23           MR. WEST: All right. I ask that this  
24 document be admitted into evidence at this time and  
25 not just for identification.

1 THE COURT: What's the exhibit number?

2 MR. WEST: We could use the next one,  
3 238.

4 MR. JACKSON: I don't have an objection  
5 to it. I do want it to be properly identified for the  
6 record. The term "census" has been thrown around.  
7 This is not the daily census of the hospital, as  
8 Mr. Sullivan is well aware. This is a record of  
9 patient -- what patients are in beds at 7:30 before  
10 discharges have occurred.

11 So I just want to make sure that in the  
12 Court's summary of the exhibit, it's clear that this  
13 is not the daily census of the hospital which is taken  
14 at midnight, as the testimony has already established.

15 THE COURT: He, at one point at the  
16 beginning, identified it as patient flow sheets, and  
17 the documents themselves say that.

18 MR. JACKSON: That's fine, Your Honor.  
19 That's what I wanted to make sure of.

20 THE COURT: That's how I'll identify  
21 them.

22 Exhibit 238, which was previously marked  
23 Number 1 for identification, contains daily patient  
24 flow sheets, and Mr. Sullivan identified it from  
25 January 15 to June 15.

1 Counsel, do you-all agree on those dates?

2 MR. JACKSON: Yes, sir.

3 MR. WEST: Yes, sir. It actually bears a  
4 logo of -- I think the file number for Mountain -- the  
5 document number in discovery, 1906, but that's a  
6 better descriptor, what you just listed.

7 (Marked Exhibit No. 238.)

8 BY MR. WEST:

9 Q. Mr. Sullivan, I'm going to show you a document  
10 that we previously supplied to the other attorneys.  
11 It's been premarked as Exhibit 221. I'll ask if you  
12 can identify this, please, sir.

13 A. Yes. This is a document I prepared.

14 Q. All right. And what were you doing with this  
15 document -- in this document?

16 A. I was just taking the information from the  
17 patient flow sheets, entering in the number of beds  
18 available on any given day in each of the units, the  
19 Cedar, Laurel, Poplar, Spruce, and Willow. Those all  
20 relate to different types of services. Willow, for  
21 example, is a child and adolescent unit with 12 beds.

22 And I also looked at the number of people who  
23 were on the waiting list on any given day. And then  
24 knowing how many beds are available, it's pretty  
25 easy to calculate what the occupancy rate was.

1           You know, for example, if you had 71 total  
2 people in a bed and divide that by 84 total beds,  
3 that gives you what your occupancy rate is on that  
4 particular day. And I will say that I didn't find  
5 many days where they -- Woodridge actually identified  
6 84 beds as being available. Generally, the number was  
7 82 or, some days, 83. A couple of times it was even  
8 less than that. But I don't believe that because of  
9 that four-bed ward that they very often have 84 beds  
10 available in the facility.

11 Q.       And you've heard the objection raised about  
12 using the term "census." When you drafted this  
13 document, you were just working from the flow sheets?

14 A.       Right. That's what it said.

15 Q.       And so there's an attribution line at the end,  
16 your source. You gave a source of this data on the  
17 last page?

18 A.       I did.

19 Q.       And what is it -- when it says "Beds  
20 Available" across the top, is that the number of beds  
21 in each unit, each of those units, respective units?

22 A.       It is. That's the license capacity, as I  
23 understand it.

24 Q.       Right. And so in your experience in looking  
25 at psychiatric hospital CON applications, do you know

1 whether many people are discharged between 12:00  
2 midnight and 7:30 in the morning from psychiatric  
3 hospitals?

4 A. Usually that's not a high time for discharges,  
5 since you're generally having to have someone pick the  
6 patient up or you're having to transport them to a  
7 different facility. Most of that activity occurs  
8 during the day. So, I mean, I can't say it's a  
9 one-to-one correspondence between the midnight census  
10 and the 7:30 or 8:00 a.m. census, but I would think it  
11 would be reasonably close.

12 Q. Right. Okay. And let's just look at your  
13 chart for a minute. And I wanted to do this in terms  
14 of -- if you assume there are 84 beds at Woodridge --

15 A. Yes.

16 Q. -- if 81 are occupied as of March 9, what is  
17 the occupancy level?

18 A. 96.4 percent.

19 Q. All right. And for that particular day, how  
20 many patients were on the waiting list?

21 A. There were five.

22 Q. So looking down through your analysis and --  
23 with the -- and keeping the difference between census  
24 at midnight and the flow sheet at 7:30 in the morning,  
25 what do you think about this analysis as a relative

1 measure of occupancy at Woodridge?

2 A. I think it's a good picture of where Woodridge  
3 is today in terms of overall utilization. This looks  
4 at it at a very granular level, in that it's looking  
5 on a daily basis and it's looking at the number of  
6 beds available by unit, and it's also providing you  
7 with some information of how many people are waiting.

8 And, you know, the wait list isn't directly  
9 correlated with the census at all times, because  
10 sometimes there may be empty beds in one unit but  
11 there's a shortage of beds in another unit, and so  
12 there's a waiting list for those beds.

13 Q. But your analysis would indicate that in the  
14 building-by-building or ward-by-ward analysis off to  
15 the right?

16 A. That's right. And so, you know, the waiting  
17 list varied from zero all the way up to 22 patients  
18 waiting on any given day during this time period.

19 Q. When were there 22 patients waiting?

20 A. I believe that was on April 24th. That was a  
21 particularly peak time in terms of occupancy and wait  
22 list for Woodridge.

23 Q. And using your analysis of the flow sheets,  
24 when was the highest level of occupancy reached that  
25 you've been able to identify from the flow sheets?

1 A. I believe that it was -- on March 30, there  
2 were 82 patients, which was 97.6. That was also  
3 repeated on April 26th and 27th. And there was one  
4 day on May 5th where there were 83 patients, which  
5 came up to 98.8 percent.

6 And so, you know, the numbers were all  
7 generally in the 70s or higher in terms of utilization  
8 of the beds. And in June the occupancy was much more  
9 consistent and very, very high throughout the month  
10 of June. So, you know, what you have is a facility  
11 that's operating very near functional capacity in  
12 terms of the utilization of its beds.

13 Q. And if 80 beds are occupied out of 84, what is  
14 that percentage?

15 A. 95.2 percent.

16 Q. And when does it -- at what level does it drop  
17 below 90 percent in terms of bed utilization?

18 A. At 75.

19 Q. So anything above 75 beds -- if it was 76  
20 beds, it would be at least 90 percent?

21 A. That's right.

22 Q. And can one assess the number of days they  
23 were over 90 percent per month by looking at your  
24 chart?

25 A. You can.

1 MR. WEST: Your Honor, I'd like to move  
2 Exhibit 221 into the record.

3 THE COURT: 221 will be marked Woodridge  
4 Hospital Daily Census by Patient Unit, March through  
5 June 2015.

6 (Marked Exhibit No. 221.)

7 BY MR. WEST:

8 Q. Mr. Sullivan, can you define -- we've seen in  
9 some of these documents the term "deferral." Can you  
10 explain what your understanding of a deferral is?

11 A. It would mean that a patient was referred  
12 for admission to a psychiatric bed and for a number  
13 of different reasons that admission could not be  
14 accomplished and therefore was deferred.

15 Deferred sometimes may mean going on a waiting  
16 list. In other cases, deferred might mean that they  
17 were actually referred to a different type of facility  
18 that would be more appropriate to the treatment of  
19 that patient.

20 Q. And have you reviewed deferral information in  
21 this case?

22 A. I have.

23 Q. And it was provided in discovery by Mountain  
24 States?

25 A. Yes.

1 Q. Let me show you a document, if I may,  
2 the first page is Mountain States -- MSHA Document  
3 2079, and ask if you can identify it, please, sir.

4 A. Yes. This is the most recent deferral data  
5 that we received, and this is for January 2015 through  
6 May 2015. And it looks at adolescent and -- this one,  
7 I think, is, if I'm looking at it correctly, multiple  
8 copies of this (indicating).

9 Q. I'm sorry. I wondered what happened to my  
10 copy.

11 (Discussion off the record.)

12 MR. WEST: I apologize for the confusion,  
13 Your Honor.

14 BY MR. WEST:

15 Q. So in the document in front of you, what MSHA  
16 document number does it have?

17 A. It has MSHA 2079.

18 Q. And what information is apparent to you from  
19 this document?

20 A. Well, first of all, it shows the total number  
21 of deferrals during this period. This is a five-month  
22 period.

23 MR. WEST: If I may, Your Honor, maybe  
24 take a moment to get this mild confusion straightened  
25 out.

1 (Pause in proceedings.)

2 BY MR. WEST:

3 Q. So what was this document referring to?

4 A. This refers to the number of referrals from  
5 January through May 2015 by county, and it shows  
6 that there were 45 total referrals. Then it shows  
7 individual counties from which those referrals came.  
8 And you can see that Sullivan is the largest with ten,  
9 followed by Greene, then Washington, and then  
10 descending down from there.

11 MR. WEST: All right. Your Honor, if I  
12 may, I'd like to make this the next exhibit.

13 THE COURT: Exhibit 239 will be marked as  
14 Adolescent Deferrals from January 2015 to May 2015 by  
15 County.

16 (Marked Exhibit No. 239.)

17 BY MR. WEST:

18 Q. I apologize for that confusion, Mr. Sullivan.  
19 It was my fault.

20 Now I'm going to show you a separate document  
21 that bears the marking at the bottom of MSHA 2080, and  
22 ask if you can identify this, please, sir.

23 A. Yes. This is the adult deferrals from that  
24 same period, January to May 2015, for Woodridge  
25 Hospital.

1 Q. And which county got the most deferrals?

2 A. Sullivan again by a pretty wide margin in this  
3 case, 76 deferrals from Sullivan County out of a total  
4 of 194. Hawkins had 17 deferrals during that period  
5 of time.

6 Q. And this is for a five-month -- first five  
7 months of 2015; is that correct?

8 A. That's correct.

9 MR. WEST: Your Honor, if I may, I'd like  
10 to make this Exhibit 240.

11 THE COURT: Exhibit 240 will be marked  
12 Adult Deferrals from January 2015 to May 2015 by  
13 County.

14 (Marked Exhibit No. 240.)

15 BY MR. WEST:

16 Q. Next, Mr. Sullivan, I want to show you  
17 Mountain States Document 2082. And what information  
18 does this document indicate?

19 A. This is adult deferral data for the same time  
20 period, but in this case it breaks it down by the  
21 reason for the deferral.

22 Q. Would you go through the different reasons,  
23 please, sir?

24 A. Sure. Of the 194 total deferrals, 126 of  
25 those were because there was appropriate bed not

1 available, and then the other categories are much  
2 smaller. Violent behavior was 22. Medical complexity  
3 was 14. Forensic, which I think usually means  
4 something related to criminal activity, is 15, and  
5 then "Other" is 17.

6 Q. All right. And this is for adults?

7 A. This is for adults.

8 MR. WEST: Your Honor, I'd like to make  
9 this Exhibit 241.

10 THE COURT: Exhibit 241 will be marked  
11 Reason for Deferrals from January 2015 to May 2015 for  
12 Adults.

13 (Marked Exhibit No. 241.)

14 MR. CHRISTOFFERSEN: Mr. West, the reason  
15 for deferrals for adolescents --

16 MR. WEST: That's next.

17 MR. CHRISTOFFERSEN: Gotcha.

18 BY MR. WEST:

19 Q. Next, Mr. Sullivan, I want to show you a  
20 document marked MSHA 2081 and ask if you can identify  
21 what information that discloses.

22 A. This is similar to the document we just  
23 discussed. It shows the reasons for adolescent  
24 deferrals from January to May 2015. There were  
25 45 total. 36 of those were related to no bed; six,

1 violent behavior; and then three in the "Other"  
2 category.

3 MR. WEST: Your Honor, if I may, I'd like  
4 to make this Exhibit 242.

5 THE COURT: Exhibit 242 will be marked  
6 Reason for Deferrals from January 2015 to May 2015 for  
7 Adolescents.

8 (Marked Exhibit No. 242.)

9 BY MR. WEST:

10 Q. Mr. Sullivan, in the course of preparing your  
11 report, you saw deferral data from earlier periods of  
12 time for Woodridge; is that correct?

13 A. I did.

14 Q. And I want to show you a document that's  
15 previously been made Exhibit 65 to the Bailey  
16 deposition, so it would be Exhibit 65 in the list.

17 Mr. Sullivan, the initial MSHA document number  
18 is 1440 on this one. What information does it  
19 provide?

20 A. It provides the same information we  
21 just looked at but for two other time periods, a  
22 seven-month period from June through December 2013,  
23 and then a five-month period from January through May  
24 of 2014.

25 Q. All right. And are similar analyses carried

1 out in this sort of collective group of documents to  
2 those individually introduced just moments ago?

3 A. Yes.

4 Q. If you would look -- these are not separately  
5 paginated, but if you would look on the June 2013 to  
6 December 2013 Reasons for Deferrals.

7 A. I've found it.

8 Q. You found it? Okay. It's about four or  
9 five pages from the back. How many total deferrals  
10 were there for adults at Woodridge in this period?

11 A. 365.

12 Q. And what was the predominant reason?

13 A. Appropriate bed not available. That was 242  
14 out of 365, so more than two-thirds.

15 Q. And if you look at the next page, are there  
16 similar data for adolescents for that time period?

17 A. There are.

18 Q. And what's the total number of deferrals  
19 there?

20 A. 75.

21 Q. And similar data follow for the subsequent  
22 time period of -- from January 2014 to May 2014; is  
23 that correct?

24 A. That's right.

25 MR. WEST: All right. Your Honor, if I

1 may, I'd like to introduce this as an exhibit. It's  
2 been made Exhibit 65 to the Bailey deposition.

3 At this point, I can't recall, but can we  
4 just keep that number.

5 MR. SWEARINGEN: Keep that number.

6 MR. WEST: Okay. This will be  
7 Exhibit 65.

8 THE COURT: Exhibit 65 will be marked as  
9 Adolescents and Adult Deferrals from June 2013 to  
10 December 2013.

11 MR. WEST: I believe it also picks up  
12 the first five months or first several months of 2014  
13 in the back.

14 THE COURT: I think there's some  
15 duplicative pages, Mr. West. Why don't you take a  
16 look at it and see?

17 MR. WEST: I apologize, Your Honor.

18 (Pause.)

19 Your Honor, you are correct. I  
20 apologize. If we could go off the record just a  
21 moment and let me get this one organized.

22 (Discussion off the record.)

23 MR. WEST: If I could just walk through  
24 this document for the record. There was an extra page  
25 on the back, just a copy page from the copy center.

1 But the first page is adolescent deferrals.

2 THE COURT: Do you have a copy that I can  
3 be looking at while you're explaining that?

4 MR. CHRISTOFFERSEN: Here you go, Your  
5 Honor.

6 MR. WEST: Exhibit 65 to Bailey. The  
7 first page is adolescent deferrals in 2013 by county.  
8 The second page is adult deferrals 2013 by county.  
9 The third page is adolescent deferrals in 2014 by  
10 county. The next page is adult -- this may be the  
11 duplicate page.

12 THE COURT: That's the one that looks to  
13 be the same.

14 MR. WEST: And I'm removing that page  
15 from the copy I'm using. And then adult deferrals  
16 2014 by county, which I don't think it occurred  
17 before. And then the next page is reasons for  
18 deferrals/adults, 2013. The next page is reasons for  
19 adolescent deferrals, 2013. The next page is reasons  
20 for adult deferrals, 2014. The next page is reasons  
21 for adolescent deferrals, 2014.

22 So I think after removing the page, the  
23 second adult deferrals by county for 2013, I think  
24 that's -- and taking off that back page, which was an  
25 extraneous copy, I believe this is an accurate copy.

1 Let me count the number of pages.

2 I get nine pages.

3 THE COURT: Counsel, everyone agree?

4 MR. JACKSON: Yes.

5 MR. WEST: Your Honor, I'll resubmit this  
6 to you. I apologize again.

7 THE COURT: Okay. So Exhibit 65 will be  
8 marked Adolescent and Adult Deferrals from June 2013  
9 to December '13, as well as January 2014 to May 2014,  
10 and also reasons for deferrals from those same time  
11 periods.

12 (Marked Exhibit No. 65.)

13 BY MR. WEST:

14 Q. Mr. Sullivan, in the course of preparing your  
15 report, did you also examine patient flow sheets that  
16 came in the discovery before your report?

17 A. Yes.

18 Q. All right. If I may, I'd like to show you a  
19 document that's marked Bailey Exhibit 46 and ask if  
20 you can identify this, please, sir.

21 A. These are the Woodridge patient flow sheets  
22 from, I believe, August 1, 2014, through September 30,  
23 2014.

24 Q. And they are -- you'll see the mark on the  
25 front page. They are Exhibit 46 from the Bailey

1 deposition.

2 A. Yes.

3 Q. And how does this form compare to the 2015  
4 forms you spoke of a moment ago?

5 A. Well, there were -- the occupancy rates were  
6 significantly higher in 2015 than they were in 2014.  
7 And as a result, the number of available beds is much  
8 smaller in 2015 than it was in 2014.

9 Q. All right. But, I mean, are these the same  
10 type of documents?

11 A. Oh, I'm sorry. I didn't get the gist of your  
12 question. Yes, they're the same type of documents,  
13 just for a different time period.

14 MR. WEST: Your Honor, I'd like to make  
15 Bailey Exhibit 46, Exhibit 46 in this matter.

16 THE COURT: And this remains Exhibit 46?

17 MR. WEST: Yes, sir.

18 MR. SWEARINGEN: Yes, sir.

19 THE COURT: Exhibit 46 will be marked  
20 Woodridge Patient Flow Sheets for a period of  
21 August 1st, 2014, to September 30th, 2014.

22 (Marked Exhibit No. 46.)

23 BY MR. WEST:

24 Q. Mr. Sullivan, you had referenced earlier in  
25 your report, and I believe in your testimony as well,

1 about the ranking of Sullivan County and the county  
2 population in Tennessee?

3 A. Yes.

4 Q. And what is your understanding of that  
5 ranking?

6 A. It's Number 9 in terms of size out of 95  
7 counties.

8 Q. And did you provide a table in support of that  
9 statement as an exhibit to your report?

10 A. Yes.

11 Q. And let me show you a document that was  
12 Exhibit 16 to your report, I believe, and ask if you  
13 can identify that, please, sir.

14 A. Yes, this is the table I prepared.

15 Q. And what does it say?

16 A. Well, what it does is it simply shows the  
17 total estimated 2015 population and then it ranks  
18 1 through 95. And in this particular chart, I  
19 highlighted Sullivan County.

20 MR. WEST: All right. Your Honor,  
21 if I may, I'd like to introduce this document into  
22 evidence. I believe it will be 243, if I'm not  
23 mistaken.

24 THE COURT: Exhibit 243 will be the  
25 Ranking of Tennessee Counties by Total Population for

1 2015.

2 (Marked Exhibit No. 243.)

3 BY MR. WEST:

4 Q. Mr. Sullivan, in your report, in the process  
5 of preparing it, did you prepare a table analyzing the  
6 Woodridge utilization over time of this inpatient  
7 unit?

8 A. I did.

9 Q. And let me show you a document that I believe  
10 is Exhibit 22 to your report and ask if you can  
11 identify it for the record, please, sir.

12 A. Yes. This is a table I prepared summarizing  
13 Woodridge Hospital's inpatient utilization from 2010  
14 through 2014.

15 Q. And this was attached to your report, so it  
16 was done prior to receipt of subsequent discovery  
17 responses?

18 A. Yes.

19 Q. What does this -- what do the data in this  
20 report say about trends in occupancy at Woodridge?

21 A. Well, prior to 2014, utilization was pretty  
22 flat, began to grow a little bit in '12, went up a  
23 little bit in '13, a little bit more in '14, and then  
24 from the data we just saw, took a relatively big jump  
25 between '14 and '15. So there was fairly limited

1 growth, though. It was over 10 percent. The real  
2 bump up in utilization seems to have occurred in the  
3 latter part of '14 and 2015.

4 Q. But even in the table set forth here that only  
5 goes to 2014, is it true that utilization went up each  
6 year?

7 A. It did. It went up. And the rate of increase  
8 was accelerating beginning in 2014.

9 Q. And we use terms like "ALOS," A-L-O-S. What  
10 is that?

11 A. That's average length of stay. So if you look  
12 at how many patients you admitted and how many patient  
13 days those patients stayed, you divide the admissions  
14 into the patient days, that tells you on average how  
15 long each patient stayed in the hospital.

16 Q. And ADC, what does that mean?

17 A. Average daily census. So that's the number of  
18 patient days divided by the number of days in the  
19 year.

20 Q. So on an average basis, such as in 2014,  
21 it would be your expectation that there would  
22 approximately 64 patient beds full with a patient in  
23 them?

24 A. Right.

25 MR. WEST: Your Honor, I would like to

1 make this the next exhibit, 244.

2 THE COURT: 244 will be marked Woodridge  
3 Hospital Inpatient Utilization, dates 2010 to 2014.

4 (Marked Exhibit No. 244.)

5 THE COURT: Mr. West, when you get around  
6 to a good stopping point, it's probably close to that  
7 time.

8 MR. WEST: I appreciate that, Your Honor,  
9 and I'm at one.

10 THE COURT: Is this a good --

11 MR. WEST: It's a good stopping time,  
12 yeah. It will give me a chance to coordinate the  
13 last set of documents for Mr. Sullivan, and then we'll  
14 finish up with him as soon as we can and turn him over  
15 for cross-examination.

16 THE COURT: Okay. We'll come back at  
17 1:00 and take lunch break now.

18 (Lunch recess observed.)

19 BY MR. WEST:

20 Q. All right. Mr. Sullivan, you had reviewed a  
21 number of exhibits to your report and some other  
22 documents before lunch. I want to return to your  
23 report. I believe you had spoken at some length about  
24 Pages 16 and 17.

25 A. Yes.

1 Q. Can you go on to what you discussed on Page 18  
2 about the final steps and then the conformity that you  
3 referenced with some service specific guidelines?

4 A. Sure. On Page 18 there's a Subsection 2 that  
5 talks about accessibility to specific special need  
6 groups. And SBH does propose to provide services  
7 to special needs groups, for example, the children and  
8 adolescent population where there's a short supply of  
9 those beds.

10 And there was discussion about SBH being able  
11 to serve cognitively impaired children and adolescents  
12 as well, which is something that not all psychiatric  
13 hospitals do.

14 And so I think the fact that they also  
15 are going to have a geropsychiatric program which  
16 addresses the specific needs of the elderly patients,  
17 I think they comply with that particular criterion.

18 Q. All right. And you also go on -- you make a  
19 summary conclusion on the bottom of Page 18. Would  
20 you reiterate that for the record, please?

21 A. Sure. On balance, looking at all of  
22 the components of the Guidelines for Growth for  
23 psychiatric inpatient services, I believe that the  
24 SBH application is consistent with those both in terms  
25 of the numerical need for beds as well as the other

1 more qualitative aspects of its proposal.

2 Q. And has anything you've heard or seen today  
3 changed your opinion in that regard?

4 A. It has not.

5 Q. And the objection's been raised by opposing  
6 counsel to the inclusion of certain letter quote in  
7 your report. Even absent those, would your report  
8 be -- absent those, would your report be different in  
9 its conclusions?

10 A. It would not. The same basic elements that I  
11 evaluated in looking at the need that we just talked  
12 about under the Guidelines for Growth would hold true  
13 in terms of looking at the overall need for the  
14 project.

15 Q. You had testified earlier about the number of  
16 Certificate of Need proceedings you've been involved  
17 in --

18 A. Yes.

19 Q. -- as an expert.

20 A. Yes.

21 Q. And over the years, have you -- other than  
22 just your recent -- and I may be repeating a question  
23 a little bit here, but I want to get back into  
24 context. Fairly recently you were involved in a  
25 geropsychiatric CON application here in Tennessee.

1 A. That's right.

2 Q. And who was the lawyer who hired you?

3 A. The lawyer in that case was Gayle Malone.

4 Q. And where does he work now?

5 A. I think he works with Mr. Jackson and  
6 Mr. Swearingen.

7 MR. JACKSON: Let the record reflect  
8 that's a recent development, but we're happy to have  
9 him.

10 THE COURT: You knew about it.

11 THE WITNESS: Nice guy.

12 MR. WEST: I believe he's from West  
13 Tennessee, if I'm not mistaken.

14 BY MR. WEST:

15 Q. And in the context of the work you've  
16 done elsewhere and in Tennessee, or especially in  
17 Tennessee, what is your practice as an expert witness  
18 in these various cases in terms of seeing letters of  
19 support or opposition in the Agency files?

20 A. Certainly that's part of the overall  
21 evaluation I do of a project. And I think letters  
22 have different relative merits. Some letters are  
23 simply form letters that an applicant or opponent  
24 might draft to get people to sign. In other cases,  
25 the letters appear to be original and express, you

1 know, more individualized sentiments about a  
2 particular project either for or against it, and those  
3 I usually give more weight to in evaluating them.

4 You know, I don't have the ability to put  
5 these people under oath and then question, you know,  
6 all the bases for their letters, but certainly part  
7 of every application that I've ever been involved in,  
8 letters of support have been, you know, an important  
9 element of it, and typically, when I'm writing an  
10 application, I will quote from the letters of support  
11 in drafting the application to try to highlight what  
12 people in the community have identified as particular  
13 needs or particular benefits to a particular type of  
14 project.

15 Q. And you had spoken earlier -- testified  
16 earlier today concerning this general background or  
17 backdrop of the psychiatric hospital situation across  
18 the country and especially in Tennessee in terms of  
19 the bed closures.

20 A. Yes.

21 Q. And I believe you had also referenced the more  
22 general aspects of the mental health care system needs  
23 both inpatient and outpatient?

24 A. Yes.

25 Q. And so what is the impact of any letters that

1 you see on -- what is the impact of those conclusions  
2 on any letters that you might have chosen to utilize  
3 or have reviewed?

4 A. Well, they were confirmation, if you will, of  
5 the sort of generalized trends that I saw from the  
6 studies and from the data that I looked at. It was  
7 more real-life, personal, you know, experiences that  
8 people had in terms of trying to access mental health  
9 services in that region.

10 Q. Were some of these letters on letterhead, for  
11 example?

12 A. They were. Many of them were on the  
13 letterhead.

14 Q. And in the reports that you have generated in  
15 various Certificate of Need cases in Tennessee, what  
16 is your general practice about citing from letters?

17 A. I generally do. You know, there was a case  
18 Mr. Jackson and I were involved in in East Tennessee  
19 involving radiation therapy services, and a letter of  
20 support from one particular group of physicians, you  
21 know, was an important aspect of the evaluation I did  
22 of that particular application, so -- you know, I'm  
23 not a lawyer, so I won't get into the evidentiary.  
24 But as a health planner, I typically look at those  
25 letters as another material factor in evaluating the

1 overall need for services.

2 Q. All right. For now I'm going to skip the  
3 letter quotes that you have in here as I'm walking you  
4 through your report. And, of course, you were here  
5 yesterday for Dr. Elliott's testimony?

6 A. I was.

7 Q. And I believe he referenced his letter that  
8 you quote.

9 A. Yes, he did.

10 Q. Starting at the top of Page 24, will you walk  
11 through the rest of your report, please, sir --

12 A. Sure.

13 Q. -- in terms of your conclusions and how you  
14 reached them?

15 A. This is still under the heading of, sort of,  
16 general need for the project. And the top of 24, I'm  
17 talking about the differences between the SBH proposal  
18 and what Woodridge currently provides, and I compare  
19 and contrast the distribution of beds.

20 You know, for example, only 12 of the 84 beds  
21 at Woodridge are for children and adolescents, so 12  
22 out of 84, whereas at SBH, 28 out of the 72 would be  
23 for children, about 37 percent.

24 So there's a different emphasis in the SBH  
25 proposal, and I think that's important because it

1 augments what's there without necessarily totally  
2 duplicating the same services that are available at  
3 Woodridge.

4 And then I note in here that Alan Levine, the  
5 president and CEO of Mountain States, was quoted in a  
6 press release from Mountain States as saying that --  
7 talking about what the needs were in Northeast  
8 Tennessee and Southwest Virginia, and he mentions  
9 addiction and access to mental health services as  
10 additional needs that should be addressed.

11 Q. And you have a quote from that press release  
12 in your --

13 A. I do.

14 Q. And let me show you a document that is listed  
15 as Exhibit 24 to your report and ask you if this is  
16 the press release information you spoke of.

17 A. Yes, it is.

18 Q. And where on this press release that was  
19 Exhibit 24 to your report is that quote from  
20 Mr. Levine?

21 A. It's on the first page, and it's a little  
22 better than halfway down. It's in quotes, and it  
23 says, "Northeast Tennessee and Southwest Virginia  
24 disproportionately suffer from serious health issues,"  
25 and then it goes on to basically repeat what I put in

1 my report.

2 Q. All right. And among those are addiction and  
3 access to mental health services?

4 A. Yes.

5 MR. WEST: Your Honor, I'd like to make  
6 this the next exhibit, 245, I believe.

7 THE COURT: 245?

8 MR. WEST: Yes.

9 MR. SWEARINGEN: Mr. West, do you know if  
10 this was one of the ones we used in Mr. Levine's  
11 deposition? Have we already marked this one?

12 MR. WEST: I just used the one that was  
13 attached to his report.

14 MR. JACKSON: So it will be what? I'm  
15 sorry.

16 MR. SWEARINGEN: 245.

17 THE COURT: Exhibit 245 will be marked --  
18 is this referred to as a press release, or what's  
19 the --

20 MR. WEST: Yes, Your Honor it's been  
21 referred to generally as a press release.

22 THE COURT: All right. And it states  
23 "Wellmont Health Systems, Mountain States Health  
24 Alliance Announce Plans to Pursue an Integrated Health  
25 System."

1 (Marked Exhibit No. 245.)

2 BY MR. WEST:

3 Q. All right. Mr. Sullivan, after your comments  
4 about the press release, would you describe what you  
5 did next in your report?

6 A. I'd mentioned this, I think, in passing  
7 earlier, that Marlene Bailey, Woodridge's director,  
8 had made some statements at the HSDA meeting saying  
9 that we agree that there -- we probably need some beds  
10 in the state.

11 When the state closed the last ten beds that  
12 they had for adolescents in Middle Tennessee State,  
13 probably around 2010, we all -- all of the private  
14 hospitals throughout the state, just like the Youth  
15 Villages worker said -- all of those hospitals  
16 thought, "What are we going to do?"

17 Then she goes on to talk about why it's  
18 not a good idea to have to move young patients long  
19 distances around the state, given the relative  
20 scarcity of beds for children and adolescents.

21 Q. And what is your conclusion from that, from  
22 these comments in this press release and the other  
23 factors laid out on this page?

24 A. I mean, it appears that -- you know,  
25 consistent with all of the other data that I've looked

1 at, that the Mountain States folks also recognize that  
2 there are gaps in the system today and that there are  
3 additional needs for psychiatric service, including  
4 inpatient beds for children and adolescents.

5 Q. Will you walk through the rest of the factors  
6 you list on Page 24 and 25 of your report?

7 A. Sure. Subsection B there talks about the  
8 existing certified services or institutions in the  
9 area. And the only hospital with psychiatric services  
10 in the service area is Wellmont Bristol Regional which  
11 I've talked about already.

12 Subsection C talks about the reasonableness  
13 of the service area. I won't repeat everything I've  
14 already said, but I do believe the service area that  
15 SBH has set forth is reasonable.

16 The next subsection talks about the special  
17 needs of service area population, talks about women,  
18 racial and ethnic minorities, and low-income groups.  
19 That's very similar to one of the standards in the  
20 Guidelines for Growth. And, again, I believe that SBH  
21 will be consistent with that.

22 And then comparison of utilization, occupancy  
23 trends and services offered by other area providers,  
24 we've already talked about that at some length.  
25 Bristol Regional is relatively well-utilized at

1 66 percent, and as we saw from the various exhibits,  
2 utilization of Woodridge, which is not in the service  
3 area but a significant provider of services, is also  
4 very highly utilized currently. So there's very  
5 limited available bed capacity to meet the needs of  
6 the residents of this area.

7 Q. You mentioned -- a little further down, you  
8 referenced the Certificate of Need matter you worked  
9 on, apparently, for Mr. Malone. Will you elaborate  
10 for the record on why you referenced that one in this  
11 report?

12 A. One of the things I've seen in psychiatric  
13 services which is a little bit different from a lot  
14 of other types of health care services is that when  
15 you don't have resources readily available and  
16 geographically convenient to the population, the  
17 utilization of those services tends to be low.

18 You know, in contrast, if somebody's having a  
19 heart attack or having appendicitis, it doesn't really  
20 matter whether you have a hospital there, they're  
21 going to go and get treatment for that.

22 But with psychiatric services, because it's  
23 a much more complex decision process about when a  
24 patient's going to seek treatment and where they're  
25 going to go and what type of treatment, geographic

1 access is a factor in that overall analysis.

2 And so when we were working on this Baptist  
3 Huntingdon case in west central Tennessee, we looked  
4 at geriatric psychiatric utilization rates in the  
5 counties around the proposed hospital site for the  
6 geriatric unit, and we found that a county to the  
7 north of where the Baptist Huntingdon Hospital was  
8 had a significantly higher utilization of geriatric  
9 psych services than did the other counties that were  
10 in the planning area that Baptist Huntingdon had  
11 identified.

12 Then we also looked at the statewide average,  
13 even though that's not necessarily, you know, your  
14 goal, is to be at the statewide average, if the state  
15 doesn't have adequate resources either, and found that  
16 the counties around Baptist Huntingdon were even below  
17 the statewide average.

18 And so, you know, the conclusion I drew from  
19 that is by having accessible services in a county, you  
20 can expect the utilization of geriatric psychiatric  
21 services, in that case, to go up, and we also looked  
22 at other examples of that in other markets.

23 And I think the same would be true, generally,  
24 for psychiatric services, that if you had higher  
25 availability of services, then you would see higher

1 utilization rates.

2 Q. Have you seen other confirmation of that in  
3 documents in this case since your report?

4 A. Yes. Dr. Collier's report presented use  
5 rates for psychiatric services for various counties in  
6 the eastern part of Tennessee, basically for the  
7 counties that are in that map that's shown on the  
8 easel there, Map 8.

9 And what that showed is that the highest rate  
10 of utilization of psychiatric services in the region  
11 was in Washington County, Tennessee, where you have  
12 an 84-bed hospital located at Woodridge. Sullivan  
13 County, while it has one provider, had a rate that  
14 was 17 percent less than the rate of utilization for  
15 Washington County. And Hawkins County, for example --  
16 Washington County's rate was 52 percent higher than  
17 the rate in Washington County [sic].

18 And all the other counties in that region  
19 had rates that were materially less than the rate of  
20 utilization for Washington County. So that is sort  
21 of further confirmation of better access results in  
22 better utilization of these mental health services.

23 So I think a reasonable expectation, if we  
24 had more accessible services in Kingsport, is that the  
25 utilization in those areas that were more proximate to

1 Kingsport and Sullivan County would go up and  
2 the population would see increased utilization of  
3 inpatient mental health services to levels that would  
4 be, you know, closer to the rate in Washington County.

5 Q. And we may get back to this later, but did  
6 you perform -- have you performed any analyses to see  
7 what would happen in all those Tennessee counties, or  
8 especially Sullivan and Hawkins and maybe the Virginia  
9 counties as well, if their utilization rates for psych  
10 services -- or inpatient psych services reached the  
11 level of Washington County's?

12 MR. JACKSON: Your Honor, please, this is  
13 outside the scope of his report. He never furnished  
14 these calculations to us. This is the first I've  
15 heard of this.

16 MR. WEST: Well, I'll save those  
17 questions for a later time in his testimony, because  
18 I think one of the things Mr. Sullivan is entitled to  
19 do is to comment on Dr. Collier's report.

20 MR. JACKSON: Well, if he was going to do  
21 that, Your Honor, I submit he should have prepared a  
22 supplemental report and given it to us sometime before  
23 today, in fairness, so that I could review it with  
24 Dr. Collier and be prepared to question him about it.

25 THE COURT: Well, there's been some

1 testimony already regarding his opinions of  
2 Dr. Collier's report.

3 MR. JACKSON: Yes, Your Honor, and I  
4 haven't objected to those, but here we're getting to a  
5 point where -- he didn't do any use rate calculations  
6 himself. He didn't study the use rate, which is  
7 actually higher in all of these counties than the  
8 average in the state. But he didn't do those  
9 calculations himself; Dr. Collier did it.

10 And now he's apparently done some  
11 further -- and I don't mind him commenting, as he's  
12 already done, on those, but now, apparently, he's  
13 done some mathematical computation where he's tried to  
14 extrapolate the use rate in Washington County to other  
15 counties, and that's the sort of thing that should  
16 have been furnished to us if he was going to be  
17 testifying about it.

18 I just don't think it's fair to present  
19 this at this late hour, a new calculation of that  
20 sort. It's one thing for him to make some general  
21 comments about Dr. Collier's report, but it's another  
22 for him to have generated some kind of calculations.  
23 I'm not prepared to cross-examine him about those.

24 THE COURT: Well, if I understood  
25 Mr. West, he's withdrawing the question --

1 MR. WEST: For now.

2 THE COURT: -- and if it comes up again,  
3 we'll address it then.

4 MR. JACKSON: Thank you.

5 BY MR. WEST:

6 Q. All right. Mr. Sullivan, on Page 26, at the  
7 top of the page you make certain references to various  
8 authorities or publications. Can you walk through  
9 those, what they are and what you did in your report?

10 A. Sure. There's a report that's published by  
11 the Substance Abuse and Mental Health Services  
12 Administration, also called SAMHSHA.

13 Q. Is that a federal agency?

14 A. It's a federal agency. And they publish this  
15 report, I believe, annually. It's called "Behavioral  
16 Health, United States," and I was looking at the 2012  
17 document. And they talk about the percentage of the  
18 population that has serious mental health disorders.  
19 And I was trying to put some magnitude of the extent  
20 of the problem in the service area that SBH was  
21 proposing to serve.

22 Based on the 2013 population estimate, there  
23 would be about 9,800 people in the SBH service area  
24 that had serious mental health problems, and that  
25 number would grow to over 10,000 by 2019. So we're

1 talking about a relatively large number of people  
2 that have serious mental health problems in this  
3 marketplace. I mean, it's not a trivial amount.  
4 And that was for adults.

5 And if we look at children and adolescents,  
6 5.3 percent were reported to have definite or severe  
7 behavioral difficulties. Applying those estimates,  
8 you get 2,400 in the current year. That would go down  
9 a little bit because the population of the child and  
10 adolescent group is going down in this area, but it  
11 still would be over 2,000 kids who have significant  
12 problems.

13 And so, you know, this is not -- you know,  
14 this isn't a solution in search of a problem. I mean,  
15 this is a problem with a lot of folks in this service  
16 area, northeastern Tennessee, that have significant  
17 psychiatric needs that an inpatient hospital could  
18 help address, in part.

19 And the last part of that discussion is just  
20 to point out that even though all of the analyses up  
21 until now is focused on the five-county service area  
22 that SBH identified, the two counties in Tennessee and  
23 the three in Virginia, the likelihood is that SBH is  
24 going to draw some patients from elsewhere.

25 Most hospitals, they have a core primary

1 service area and then they have sort of a scattering  
2 of patients that come from surrounding areas and  
3 sometimes from, you know, fairly distant areas, you  
4 know, randomly choosing to come there for a variety of  
5 reasons.

6 And so approximately 20 percent of the volume  
7 that we can expect to serve would likely come from  
8 outside of the five-county area. So all of the  
9 utilization that this hospital is going to generate  
10 isn't necessarily going to come just from these five  
11 counties. Some of it will come from other areas  
12 farther away from Kingsport just by the nature of how  
13 health care services work.

14 Q. And going on to economic feasibility, what is  
15 your conclusion on that and on what documents did you  
16 base that?

17 A. Well, first of all, in terms of having  
18 adequate funds to complete the project, I believe  
19 we've already had some testimony about that, and I  
20 think they've demonstrated -- SBH has demonstrated  
21 they can do this.

22 The reasonableness of the project costs, I've  
23 worked on a lot of hospital construction projects,  
24 and this is a very efficient project with only  
25 \$12 million, approximately, to build a 72-bed

1 facility. That's a very efficient price. So from  
2 that standpoint, I think the construction costs and  
3 other costs are very reasonable.

4 The revenues from the proposed project, I  
5 believe Mr. Shaheen's already talked about how those  
6 were developed, and I think they look reasonable as  
7 well. And the applicant does plan to participate in  
8 state and federal programs in terms of reimbursement.  
9 So for all of those criteria, I believe the applicant  
10 has demonstrated conformity with these particular  
11 criteria.

12 And then the alternatives considered, there's  
13 discussion of that on Pages 27 and 28. And what I  
14 postulated is the alternatives are really to do  
15 nothing and construct no facility or to build  
16 something smaller.

17 And I don't believe that not building a  
18 facility in Kingsport is really the best alternative  
19 because it won't do anything to address the shortage  
20 of services and the lack of access to care that  
21 exists.

22 A facility smaller than 72 beds is a  
23 possibility, but given that the Guidelines for Growth  
24 identified a need for more than 72 beds and given that  
25 the overall level of population in the community to be

1 served is over 300,000, I really don't believe that  
2 building a smaller facility would be that  
3 advantageous.

4 If the need was there to expand later on, you  
5 would just incur additional costs, have to go back and  
6 retrofit beds into a facility, when, if you've already  
7 identified a need on the front end, then it makes  
8 sense to go ahead and build a facility of that size.

9 And there's another important part to having a  
10 larger facility, and that is when you have a larger  
11 facility, you can treat different patient populations  
12 within certain segments of the populations that you're  
13 serving.

14 An example of this would be if you have child  
15 and adolescent patients that you're serving, having a  
16 bigger facility lets you separate the children from  
17 the adolescents. That's very difficult to do, for  
18 example, in a 12-bed facility like Woodridge, because  
19 you don't have a lot of patient volume that you can  
20 develop, you know, separate programs for.

21 Similarly, on the adult side, you can separate  
22 adults into patients, tracks that deal with different  
23 diagnoses, different needs of those patients. So  
24 having a larger facility gives you a clinical  
25 advantage in terms of being able to separate those

1 patients into different treatment arenas. And so for  
2 all of these reasons, I don't believe that a better  
3 alternative would be to not build a hospital or to  
4 build a smaller hospital.

5 And then finally, for the same reasons, under  
6 Subparagraph F, "Availability of less costly or more  
7 effective alternative methods of providing the  
8 benefits intended by the proposal," I don't believe  
9 there is an alternative that's less costly or more  
10 effective.

11 Q. And going on to the final factor, contribution  
12 to orderly development, can you discuss your analysis  
13 and conclusions there on that?

14 A. Sure. You know, my overall conclusion is  
15 that I believe it will contribute to the orderly  
16 development. And the first is -- relates to the  
17 relationship of the proposal to the existing health  
18 care system. And I think the testimony I've heard  
19 so far and what I've reviewed in the application is  
20 that it is the intent of SBH to become an integral  
21 part of the health care delivery system within its  
22 service area in terms of reaching out to folks in the  
23 community, community-based organizations involved in  
24 mental health treatment -- schools, law enforcement  
25 agencies, other types of outpatient providers -- and

1 to try to integrate their services with those. So  
2 this will be an enhancement to the overall delivery  
3 of mental health services in this area.

4 There's a second criterion under here, B,  
5 which talks about the positive or negative effects  
6 attributed to duplication or competition. And I think  
7 competition is a material consideration in this case.  
8 When you look at the availability of services, it's  
9 a very uneven competitive playing field. Woodridge  
10 really controls the vast majority of -- I should say  
11 Mountain States controls the vast majority of the  
12 psychiatric care that's available to Sullivan County  
13 and other service area county residents. Wellmont,  
14 who's another large health care system, has a unit at  
15 Bristol Regional. And I don't know if we want to get  
16 into the discussion of the merger.

17 Q. Well, just go ahead with your conclusions for  
18 now.

19 A. Okay. And so I believe that SBH would present  
20 a competitive alternative to Woodridge and to Mountain  
21 States. They have a way of providing services, and  
22 I'm not criticizing their approach, but SBH has their  
23 own approach.

24 And SBH is going to attract health care  
25 professionals, as has already been testified to, to

1 the community, specialized psychiatrists, other  
2 specialized staff, and they're going to provide  
3 services in a different way, and that will give  
4 patients increased choice in terms of where they  
5 want to go.

6 And it will also, potentially, stimulate  
7 price competition as it relates to contracting with  
8 third-party payors in the market. So there are  
9 benefits to having a competitor that's outside of the,  
10 sort of, two-health-care-system market that exists  
11 right now.

12 And so from that standpoint, I think whatever  
13 duplication that's occurring -- and I would view this  
14 as necessary duplication. In health planning, when  
15 you talk about duplication, you talk about unnecessary  
16 and necessary duplication. Unnecessary would be where  
17 there's no need for what you're proposing and you're  
18 just simply duplicating what somebody else already  
19 does. In this case, it's necessary duplication  
20 because we need to have more inpatient psychiatric  
21 beds available in the community.

22 And then the final aspect of this is looking  
23 at the impact of the project on existing providers.  
24 As I've already mentioned, by and large, Bristol  
25 Regional is serving a Virginia-focused population.

1 And so the primary facility that would experience any  
2 material impact would be Woodridge.

3 And so I have a discussion here about the  
4 analysis that Woodridge presented at the HSDA meeting.  
5 And through looking at various discovery documents  
6 that were provided, trying to evaluate the  
7 reasonableness of the impact analysis that was  
8 presented before the HSDA -- and I don't know how  
9 much detail you want me to go into here, but...

10 Q. Well, let me ask you this: Do you know  
11 whether -- in the fiscal year 2014, from the discovery  
12 documents you've referenced, did Woodridge show a  
13 profit?

14 A. They did.

15 Q. All right. And so how consistent is the fact  
16 that they showed a profit with the representations  
17 made to the HSDA about their current situation in  
18 2014?

19 A. Well, the representations to the HSDA in terms  
20 of the current financial position of Woodridge was  
21 that they were losing significant dollars.

22 MR. JACKSON: Your Honor, please, I  
23 would object to the testimony about the presentations  
24 before the HSDA, which this is a de novo proceeding.  
25 Dr. Collier has offered an economic impact analysis

1 which he's reviewed and presumably has some comments  
2 on. But to go back to what was presented, now -- has  
3 it been a year ago -- before the Agency when we have  
4 more recent financial data, we have a more recent  
5 analysis by Dr. Collier, it just seems that it's  
6 irrelevant what presentation was made before the  
7 Agency a year ago or whenever it was. I'm sorry I  
8 don't remember exactly.

9 MR. WEST: Your Honor, I think it's  
10 highly relevant, and I can -- for the reason that  
11 discovery revealed certain activities within Mountain  
12 States' accounting process, if nothing else. And  
13 that's the point I'm trying to get to, Your Honor.  
14 I've got exhibits from Mountain States' discovery I'm  
15 about to present to Mr. Sullivan.

16 MR. JACKSON: Well, what is the relevance  
17 of our accounting practices? He didn't perform an  
18 impact analysis, as we'll cover when I question him.  
19 So if he has criticisms of Dr. Collier's impact  
20 analysis, I think that's fair game and he should be  
21 permitted to express them, but if he's just going to  
22 be commenting on accounting practices of Mountain  
23 States, A, it's just irrelevant to the proceeding.

24 I mean, I don't understand what -- where  
25 they're going with this, except they want to -- I

1 think where they're going is they want to criticize a  
2 moot analysis that was done a year and a half ago and  
3 presented to the HSDA and they don't want to talk  
4 about the analysis Dr. Collier did which is actually  
5 going to be offered into evidence in this proceeding.

6 And so to me this line of questioning has  
7 no relevance in a de novo proceeding. And I haven't  
8 heard yet an articulation of exactly what the point of  
9 this questioning is.

10 THE COURT: Well, it started with  
11 -- under the guise of competition, is where the  
12 line of questioning arose. I'm going to allow the  
13 testimony. Of course, if there's something more  
14 recent and more relevant, then obviously that will  
15 affect the weight given to this testimony.

16 MR. JACKSON: Thank you, Your Honor.

17 BY MR. WEST:

18 Q. Mr. Sullivan, I want to show you a set of  
19 pages of documents from Mountain States. These were  
20 Exhibit 27 to the McDevitt deposition. I'd ask if you  
21 can state whether you've seen these before.

22 A. (Reviewing documents.) I have.

23 Q. And if you'll look through here -- if you look  
24 on MSHA Page 74, toward the back.

25 A. Okay.

1 Q. On Page 74, what does Ms. McDevitt, Kasey  
2 McDevitt, state in that email to you, Mr. Sullivan?

3 A. She had received an impact analysis that  
4 assessed what the bottom line loss would be to  
5 Woodridge Hospital if the SBH project were to be  
6 approved, and that came from a Debbie Wyse who worked  
7 at Mountain States at the time. And the impact  
8 analysis that she received showed a loss of only  
9 \$50,000 on the bottom line.

10 Q. That would be for the second year?

11 A. That would be for the second year. And a  
12 \$30,000 loss in the first year. And she indicated  
13 that "The financial impact of removing those patients  
14 is not as dramatic as I would have expected, only a  
15 difference of net income of 50,000 in Year 2, 2016."

16 And then she goes on to talk about, "I would  
17 expect the direct costs to vary with volume but not  
18 all of the indirects. In the past, I have used a  
19 ratio fixed versus variable for indirects when  
20 developing pro formas. Just wondered if we should  
21 assume all of the indirects would vary per case, or if  
22 there's a ratio of fixed variable you would suggest."

23 And so, you know, subsequently, the analysis  
24 was modified to show much more variability in the  
25 costs. And a lot of the costs which were reflected as

1 direct costs in the first analysis were reclassified  
2 as fixed indirect costs in the subsequent analysis.

3 Q. But at least as far as the initial analysis  
4 goes, Ms. McDevitt concluded, at least according  
5 to this email, the impact in the second year of  
6 SBH-Kingsport's operation would be only about \$50,000  
7 on Woodridge?

8 A. That's correct.

9 MR. WEST: Your Honor, I'd like to move  
10 Exhibit 27 into the record, please.

11 THE COURT: Did you say 47?

12 MR. WEST: It's 27.

13 THE COURT: Exhibit 27 would be marked a  
14 series of e-mails between Kasey McDevitt and Debbie  
15 Wyse, April, May, and June of 2014.

16 (Marked Exhibit No. 27.)

17 BY MR. WEST:

18 Q. Mr. Sullivan, what is your ultimate conclusion  
19 in the section of your report entitled Impact?

20 A. Well, it's -- I guess it's a couple of  
21 different points. I mean, first of all, Mountain  
22 States, I think, has attempted to isolate the impact  
23 just on Woodridge Hospital.

24 And I think as perhaps has been mentioned  
25 already in this hearing, Woodridge is not a distinct

1 hospital. It's simply a service of Johnson City  
2 Medical Center, a satellite hospital within Johnson  
3 City Medical Center, and Johnson City Medical Center  
4 itself is just a d/b/a of Mountain States Health  
5 Alliance.

6 So I think that maybe the proper context in  
7 assessing the impact would be to look at the impact on  
8 Johnson City Medical Center as a starting point and on  
9 Mountain States Health Alliance as a second  
10 consideration.

11 And when you look at -- the most recent data I  
12 had on Johnson City Medical Center was for 2013 from  
13 their joint annual report, and they had a bottom line  
14 of over \$30 million in fiscal year 2013. And so even  
15 if the impact were as large as being projected at the  
16 time of the HSDA hearing or Dr. Collier's projections,  
17 which are in the same ballpark, this is a very large  
18 organization, a profitable organization; this impact  
19 would not be highly detrimental, would not require  
20 them to discontinue services. This is the type of  
21 impact that happens when you approve a new facility  
22 that's needed to enhance access to care.

23 And that's the balancing act I was talking  
24 about before. Anytime you do an impact analysis,  
25 you're really weighing does the impact on existing

1 providers create a problem that's greater than the  
2 benefit that would result from the approval of the  
3 project.

4 And in this case, I think the weight is more  
5 on the benefit that accrues to the community from the  
6 approval of this project versus the dollar impact that  
7 would occur to Woodridge as a consequence of SBH being  
8 approved.

9 Q. And in the joint annual report that you  
10 reference for Johnson City Medical Center, was that  
11 profit number you gave, or excess of revenue over  
12 expenses?

13 A. It was.

14 Q. Was it after the allocation of corporate  
15 overhead was applied?

16 A. Yes.

17 Q. So any corporate overhead that had been  
18 applied was taken out before they -- I mean, the  
19 31 million is free and clear of any corporate  
20 overhead?

21 A. That's right. You know, the operating income  
22 would be a bigger number than that.

23 Q. So your ultimate conclusion on all the  
24 three factors -- need, economic feasibility, and  
25 contribution to orderly development of health care --

1 can you summarize that briefly?

2 A. Sure. I think the need is clearly documented  
3 for the quantitative and the qualitative aspect of  
4 what we looked at in terms of need. The economic  
5 feasibility in terms of ability to finance, the  
6 appropriateness of this as an alternative, I think,  
7 has been demonstrated.

8 And then, finally, the orderly development,  
9 the ability to enhance the availability of services to  
10 integrate with the existing mental health community,  
11 at the same time, whatever impact that would occur  
12 would be one that would be tolerable for the  
13 organization that would be experiencing the impact,  
14 and at the same time is outweighed by the benefits  
15 associated with the development of this proposed  
16 project.

17 Q. And so what do you recommend that the HSDA do?

18 A. I would recommend approval.

19 MR. WEST: Your Honor, at this time I'd  
20 like to move Mr. Sullivan's report into evidence. I  
21 think it's been marked Exhibit 80, if I'm not  
22 mistaken.

23 MR. JACKSON: Your Honor, I would renew  
24 my objection to the portions of his report where he  
25 simply word for word copied letters of support for the

1 project for the reasons previously stated.

2 MR. WEST: Your Honor, my response to  
3 that is that Mr. Sullivan has, I think, adequately  
4 demonstrated that it is customary in these cases and  
5 experts, such as he is, routinely look at those  
6 letters and utilize them. They're in the Agency  
7 files. They're public records available to anyone,  
8 and I think -- and the Agency itself cites them, in my  
9 personal experience -- this is argument -- that they  
10 cite them and utilize them in their decision-making.  
11 So from that standpoint, I disagree with my colleague,  
12 Mr. Jackson.

13 THE COURT: And so I'm clear -- and I  
14 think Mr. Sullivan prefaces in his report that these  
15 were only -- well, he says these are excerpts from  
16 selected letters of support. So there's additional  
17 letters of support. And based on our argument,  
18 there's also letters of opposition out there too.

19 MR. JACKSON: There are, Your Honor,  
20 and they're all hearsay and they're all people that  
21 if they were subject to cross-examination, I could  
22 point Your Honor to several things in those letters  
23 that are included in his report which are false  
24 factually, yet he did no investigation, he admitted in  
25 his deposition, to verify anything any of those people

1 said, and they have not been subject to  
2 cross-examination. Any of them could have been  
3 brought here to testify.

4 SBH is a big organization with able  
5 counsel. They could have gone and secured affidavits.  
6 They could have secured deposition testimony, or they  
7 could have brought any of those people here before  
8 Your Honor so that these people could be examined  
9 properly. And what they're trying to do is just dump  
10 it all in.

11 And just because an expert looks at  
12 something doesn't make it admissible. It doesn't  
13 change that it's hearsay. And there's no exception  
14 to the hearsay rule for things experts look at, except  
15 under -- they can refer in their testimony, under  
16 Rule 702, to things that they -- an expert customarily  
17 relies on, but that doesn't mean that all those things  
18 are admissible.

19 THE COURT: 703.

20 MR. JACKSON: I'm sorry. 703. Thank  
21 you, Your Honor. So for all those reasons, I just  
22 don't think it's appropriate. It really puts us at a  
23 disadvantage too because, as I say, I think some of  
24 them are factually incorrect. At least one of them  
25 was withdrawn as he admits in one of his footnotes.

1           So you've got opinions by people who  
2 aren't here to testify, aren't being cross-examined,  
3 one of them has repudiated the opinion. He's done  
4 nothing to verify them, so it's just -- they're not  
5 proper for our record.

6           THE COURT: And, Mr. West, I assume  
7 you're traveling under 703?

8           MR. WEST: I'm not the scholar of the  
9 rules as my colleague Mr. Grant is, but I believe so.

10          MR. GRANT: He is traveling under 703,  
11 Your Honor.

12          THE COURT: All right. And, of course,  
13 when you look at 703, facts and data that are of a  
14 type reasonably relied upon by experts in forming  
15 their opinions need not be admissible into evidence.  
16 Of course, Mr. Sullivan has said that the letters do  
17 not affect his opinion regarding need. That testimony  
18 was elicited. And so he finds the need without the  
19 letters, based on his own testimony.

20          And he testified that the letters are  
21 part of his overall evaluation. And I assume when he  
22 said he looked at letters, that he's talking about for  
23 and against, when he looks at letters, presumably. I  
24 don't think he specifically said, or if he did, I  
25 didn't catch it. I know he just said part of his

1 overall evaluation is to look at letters.

2 MR. WEST: Well, Your Honor, I think he  
3 looked at the file of the Agency, is my understanding  
4 of the list of his documents, so that file would  
5 include letters of opposition as well as letters of --  
6 I didn't mean to interrupt.

7 THE COURT: That's fine. So there's  
8 letters, as we've already established, for and  
9 against. He also, at the beginning, in his report,  
10 in this section, he said that they're excerpts from  
11 selected letters of support, so it's obviously not  
12 all the letters. And I'm not sure, based on his  
13 statement, that it's -- a particular letter is the  
14 entire letter since he mentions that it's excerpts.

15 So I'm a little bit concerned because  
16 the end of Rule 703 talks about that the Court doesn't  
17 have to allow testimony if there's any indication of a  
18 lack of trustworthiness. And I bring that up because  
19 there's a footnote to one of the letters that one of  
20 the individuals withdrew his support, and there's  
21 about 10 or 11 letters. One of them you've already  
22 introduced through a witness yesterday.

23 And, of course, I haven't read his  
24 letter, but the beginning of his letter, Dr. Elliott,  
25 he states his position and, of course, we found out

1 yesterday that's no longer accurate, although I'm  
2 sure his opinion, based on his testimony yesterday,  
3 is probably going to be consistent with the letter.

4 So I don't know, within these, if there  
5 might be other inconsistencies. So I'm a little  
6 concerned about the trustworthiness because,  
7 particularly, one of them has already been withdrawn.

8 MR. WEST: Well, Your Honor, we would be  
9 happy -- although we would want to reserve this issue,  
10 if we need to, for appeal, but I would like to get  
11 this report in the record, and it's possible to enter  
12 it into the record without the letter pages, because  
13 Dr. Elliott's letter has been introduced as evidence.

14 THE COURT: And I don't have any problem  
15 with his letter. I'm assuming counsel's not objecting  
16 to that.

17 MR. JACKSON: No, Your Honor.

18 THE COURT: And so ultimately my ruling  
19 is that the report will be admitted. However, those  
20 letters, other than Dr. Elliott's, should be stricken,  
21 again, unless those people are going to be here as  
22 witnesses and you can get them in like you did  
23 Dr. Elliott's yesterday.

24 MR. WEST: May I tender the report for  
25 identification? Then we'll -- I just want to have his

1 report here, and we can extract those pages.

2 MR. GRANT: We can redact the pages  
3 later.

4 MR. WEST: We can redact the pages.

5 THE COURT: Sure.

6 MR. WEST: I want to make sure it's in  
7 the record.

8 THE COURT: We'll go ahead and mark it  
9 now, and I think you-all can work up a method -- and  
10 it's marked 80; is that correct?

11 MR. WEST: It's marked on mine as 80,  
12 because it was a deposition. I believe you have a  
13 copy of it.

14 THE COURT: All right. So Exhibit 80  
15 will be marked as the report of Daniel Sullivan of  
16 June 2015.

17 (Marked Exhibit No. 80.)

18 BY MR. WEST:

19 Q. Mr. Sullivan, among the things that we asked  
20 you to do also, that you were retained as an expert  
21 for, was also to examine any expert reports of their  
22 health planning -- Mountain States' health planning  
23 expert; is that correct?

24 A. Yes.

25 Q. And have you examined Ms. Collier's report?

1 A. I have.

2 Q. I refer to her as Ms. Collier because that's  
3 what she said it would be in the deposition. She is a  
4 Ph.D. in English. It's my understanding that you and  
5 Ms. Collier used to work together.

6 A. We did, 1980 until '85.

7 Q. You've seen her report. What is your analysis  
8 of it just speaking in your role today?

9 A. A significant portion of her report related to  
10 the issue of service area definition. And the Map 8  
11 that's on the easel now, I think, is her -- what she  
12 called her alternate service area map, what she was  
13 recommending would be the appropriate service area  
14 for determining the need for psychiatric beds in this  
15 region. And I have certain fundamental disagreements  
16 with that particular service area definition, if I  
17 could talk about that.

18 Q. Yeah. Go ahead.

19 A. You know, I've spent some time already talking  
20 about why Washington County, Tennessee, I don't  
21 believe should be included in the service area, and I  
22 presented a fair amount of historical data from other  
23 providers to document why I thought that was the case.

24 As I read Dr. Collier's report, the bases she  
25 used for including Washington County in there was data

1 from Indian Path Pavilion from 2006 to 2009 before it  
2 was closed by Mountain States and then also looking at  
3 the Woodridge patient origin data and then the area  
4 that Woodridge serves.

5 Let me take the second part of that first. I  
6 don't believe, for all the reasons I've already said,  
7 that the area Woodridge serves is that relevant to  
8 what the service area would be for a hospital located  
9 in Kingsport, Tennessee. Different situation. Not  
10 part of a major medical center. Would be facing  
11 competition.

12 Right now Woodridge has no real competition  
13 in terms of another comprehensive provider. In this  
14 case, a hospital in Kingsport would have a significant  
15 competitive alternative in Woodridge located in  
16 Washington County.

17 So I think it would be very difficult for  
18 SBH or any other hospital going into Kingsport who  
19 proposed to provide psych services to draw a material  
20 number of patients out of Washington, Tennessee.

21 Q. Washington County.

22 A. Washington County, Tennessee. And that's  
23 probably the biggest deal in the -- in her overall  
24 redefinition of the service area. Because if you just  
25 took Washington County out and kept everything else

1 the same, there would be a need for even more beds  
2 than what was projected by SBH and what I projected in  
3 my application, even using all these other counties,  
4 which I don't agree with.

5 And let's talk a little bit about Washington  
6 County, Virginia, and Russell County, Virginia. First  
7 of all, I've not seen any data that would indicate  
8 that any provider in Sullivan County, Tennessee,  
9 serves a material number of patients from Russell  
10 County, Virginia. It wasn't included in Woodridge's  
11 service area. It's not in Johnson City Medical  
12 Center's service area.

13 The patient origin data I looked at from all  
14 the other providers in Sullivan County didn't show  
15 material numbers of patients coming from Russell  
16 County. And they would have to drive through  
17 Washington County, Virginia, where there is a 28-bed  
18 freestanding psychiatric hospital, past the 12-bed  
19 unit at Wellmont Bristol Regional to get to Kingsport,  
20 which would still be a considerable distance to the  
21 west.

22 So I don't think it's reasonable to expect  
23 that county to have any material impact on the  
24 utilization of the SBH facility in Sullivan County.  
25 If you drop that facility out, do nothing else, then

1 the bed need goes from -- what her report showed, I  
2 think, was about 39 beds or 38 beds in the second year  
3 of operation to about 53 beds. And so we're getting  
4 close to the 72 beds at that point.

5 Washington County, Virginia, for some of  
6 the same reasons, there's no reason to think that a  
7 significant number of people are going to leave that  
8 area. Again, that has not been a major source of  
9 patients for other providers located in Sullivan  
10 County.

11 When you look at the concentration of  
12 psychiatric beds in that part of the service area, you  
13 have 28 at Ridgeview, you have 12 at Bristol Regional,  
14 and you have 20 up in Russell County at the Clearview  
15 facility. So you've got 60 psychiatric beds already  
16 located in immediate proximity to that population.  
17 So why would those people drive away from all those  
18 facilities and go over to Kingsport to receive care?

19 Again, that's not been a significant source  
20 of patients for Woodridge historically nor for the  
21 HealthSouth rehab facility. And so I just don't think  
22 that those counties have any place in the service area  
23 for an SBH hospital. And then if we look at Carter  
24 County, again, there's not a lot of patient flow from  
25 Carter County into Kingsport now and to the existing

1 facilities.

2 And Unicoi County, patients would essentially  
3 have to drive through Washington County, past the  
4 Woodridge facility and drive a considerable distance  
5 farther to get to the facility in Kingsport, which  
6 wouldn't make a lot of sense.

7 And then you have Greene County where the  
8 Takoma facility is. Again, not a significant source  
9 of patient referrals historically for Sullivan County  
10 providers, wouldn't expect to draw a material number  
11 of patients there. So, in general, I think that the  
12 service area that she has defined is one that was  
13 result-driven, and that is to try to show that there  
14 would be not enough need for the proposed 72-bed  
15 project.

16 I will note that even using her, what I think  
17 is unreasonable, service area, she still showed a need  
18 for 30 to 38 beds in this expanded service area. So  
19 even she acknowledges that there still is a need for  
20 some additional beds in the area. And I think if  
21 you more reasonably draw the service area and do the  
22 calculations as I've done in my report, that you would  
23 show that there readily would be 72 beds needed.

24 Q. And these counties that you reference, such as  
25 Russell and Washington and Virginia and Carter, Unicoi

1 and Takoma in Tennessee, how did the Indian Path  
2 Medical Center service area treat them in the latest  
3 CH&A?

4 A. They were not included. As we talked about,  
5 essentially the Indian Path Medical Center is the  
6 western half of Sullivan, Hawkins County, and then  
7 Virginia counties. And I think that's more of the  
8 orientation for the Kingsport folks, is west and  
9 north, in terms of health care service patient flows.

10 Q. You've been asked -- and I don't want to  
11 belabor the point, but the impact analysis that she  
12 used that you cited in your testimony, why didn't you  
13 generate an impact analysis?

14 A. I usually don't do one initially myself, in  
15 part, because I don't have the internal information  
16 from the opponents, financial records, I don't have  
17 all of the detailed information about their patients.  
18 And generally, when I'm in this position as being an  
19 applicant, I try to respond to what the opponents say,  
20 you know, to try to test the reasonableness of an  
21 impact analysis, where they have access to the  
22 internal information.

23 And so, in this case, that's what I did. I  
24 viewed the impact analysis that Mountain States had  
25 done at the time of the HSDA meeting and I commented

1 on that. And I'm prepared to offer opinions about  
2 Dr. Collier's impact analysis today.

3 Q. And what I intended to ask you about was use  
4 rate analysis.

5 A. Okay.

6 Q. Why didn't you employ a use rate analysis?

7 A. Because I don't have the data. The data to do  
8 use rates is part of -- Tennessee Hospital Association  
9 collects very detailed discharge data from individual  
10 hospitals, and it has all kinds of -- zip code, county  
11 of origin, patient diagnosis, diagnostic category, I  
12 mean, all these different things are in there.

13 The only data that I can access as an outsider  
14 is data on the joint annual report of hospitals, and  
15 that's limited because it doesn't necessarily capture  
16 patients who are going outside the service area, for  
17 example, or if the hospital -- if the psych services  
18 are provided as part of a general hospital, then it  
19 wouldn't break out the patient origin for the  
20 psychiatric services separately.

21 So I needed someone like Mountain States  
22 that's a member of THA to extract the data, and then  
23 once they extract it, then I can look at it and  
24 evaluate it, which is what I did earlier.

25 Q. Well, let me ask you: If you were -- this is

1 a question about process. If you were going to use  
2 the use rate analysis that she provided for the  
3 various counties in Tennessee --

4 A. Yes.

5 Q. -- and if you were going to apply the  
6 Washington County, Tennessee, use rate to any other  
7 county that you had population numbers for, what would  
8 be the process that you would use to do that?

9 A. Well, it's pretty simple. You would determine  
10 what the Washington County use rate is and then  
11 calculate that per 100,000 or whatever denominator you  
12 wanted to use, and then you would multiply it times  
13 the population in a given county and that would give  
14 you a number of expected patient discharges. And then  
15 you would assume some length of stay that would be  
16 associated with those patients. You calculate the  
17 total number of patient days. Then you could  
18 calculate an average daily census that you would  
19 expect from that. And typically, with bed need, you  
20 would assume an occupancy standard. In this case, I  
21 would use 80 percent. And I would divide the average  
22 daily census by 80 percent to come up with the number  
23 of beds that were needed. So it's a fairly standard  
24 approach.

25 Q. But if, for example, Hawkins County's use rate

1 was significantly below Washington County's use rate  
2 and you used the Washington County use rate to apply  
3 it to Hawkins County population, what would you expect  
4 the number of admissions from Hawkins County to do if  
5 they hit the Washington County use rate?

6 A. To go up by over 50 percent.

7 Q. And so there's a -- there is a, sort of,  
8 numerical relationship that can be identified between  
9 the use rates applied to populations?

10 A. That's right. Because if the population is  
11 a constant, then if you're using different use rates,  
12 the differences in the use rate would come out in the  
13 ultimate number of patients projected.

14 Q. All right. And as you said -- and is this  
15 essentially a calculus problem or an arithmetic  
16 problem?

17 A. It's an arithmetic problem.

18 Q. And, once again, given that -- if you have  
19 the population and you have the use rate that you're  
20 normalizing to or whatever you want to call it,  
21 adjusting to, then you can perform those calculations  
22 and come up with the -- come up with the number of  
23 projected days, for example, or any other similar --

24 A. Sure. Days, average daily census, beds,  
25 whatever you wanted to calculate.

1 Q. All right. Have you reviewed any Mountain  
2 States data that extends back to the time before  
3 Mountain States acquired Woodridge?

4 A. Yes.

5 Q. Let me show you a Mountain States document,  
6 1597, and ask if you can identify this. Tell me what  
7 it says.

8 A. This is a document that looks at -- in various  
9 ways, looks at trends in utilization of psychiatric  
10 services and --

11 Q. What time period does it appear to cover?

12 A. It covers the period from 2005 through 2010,  
13 projected, I guess is what the "P" means, and it says  
14 it's for the Mountain States Hospital -- Health Care  
15 Alliance service area.

16 Q. And what does it show about the relative  
17 utilization between Woodridge and Indian Path for  
18 those years?

19 A. It shows that the -- at the starting point,  
20 if you go back to 2005, which, I think, is just before  
21 Mountain States just took over ownership of Woodridge,  
22 if I recall --

23 MR. JACKSON: Your Honor, please --  
24 excuse me, Mr. Sullivan -- I would object to the  
25 relevance of this. This is going back ten years.

1 It's ancient history to say the least. It's before  
2 Mountain States even owned these facilities, as has  
3 already been established. I just don't see the  
4 pertinence of any of this to the issue of whether a  
5 new hospital is needed in 2015.

6 MR. WEST: Your Honor, if I may, the  
7 pertinence is in the results that it shows, that  
8 utilization was higher back in that period than it has  
9 been recently or up until recently. And Mr. Sullivan  
10 has already testified about the sort of patterns of  
11 utilization and what has happened to beds. This  
12 document goes back to the time that Woodridge and the  
13 Mountain States facilities were separate, and so it  
14 gives you --

15 MR. JACKSON: I'll withdraw my objection.

16 MR. WEST: Okay.

17 BY MR. WEST:

18 Q. What does this document indicate about the  
19 grand total of psychiatry cases? It looks as though,  
20 to me, it describes -- what's the grand total of these  
21 cases? What pattern do they show over the years?

22 A. Well, in 2006, there was a pretty significant  
23 increase in the number of psychiatric patients served  
24 in the Mountain States service area. It went from  
25 7,600 the year before to over 9,000 in 2006. And then

1 it went down a bit, and then took a steep dive in 2009  
2 and 2010. In 2009 and '10 is when the Indian Path  
3 Pavilion was being wound down for closure.

4 And you can see that in 2005, Indian Path --  
5 it says Indian Path Medical Center, but I believe that  
6 means Indian Path Pavilion, because I don't believe  
7 there are separate psychiatric beds at Indian Path  
8 Medical Center -- had almost twice as many psychiatric  
9 discharges as Woodridge did.

10 By 2009, the last, really, full year of  
11 operation for Indian Path Pavilion, it had dropped  
12 to a fraction of its previous volume. Woodridge had  
13 doubled in volume, but the overall service area lost  
14 a material number of psychiatric patients.

15 And, you know, I think that's meaningful  
16 because it shows that when you close a hospital,  
17 utilization goes down. That's not a big surprise to  
18 health care planners, but it does show that adding a  
19 hospital in there has the potential to increase the  
20 utilization of services, which is important both in  
21 terms of caring for patients and also important in  
22 assessing the impact of a new project on existing  
23 providers.

24 MR. WEST: Your Honor, I'd like to move  
25 this document into the record as 246, I believe.

1 THE COURT: All right. Exhibit 246  
2 will be marked as a document which the witness has  
3 identified as showing trends in utilizations of  
4 psychological services from 2005 to 2010.

5 (Marked Exhibit No. 246.)

6 THE COURT: Mr. West, we don't need this  
7 page here, do we?

8 MR. WEST: Let me see, Your Honor. The  
9 reason that's on there is it identifies the Mountain  
10 States document number at the bottom.

11 THE COURT: Okay. We'll keep it on  
12 there, then, so there's no confusion.

13 BY MR. WEST:

14 Q. Mr. Sullivan, you spoke earlier about -- in  
15 discussing your report, as I recall it, you mentioned  
16 the financial results at Woodridge for 2014.

17 A. Yes.

18 Q. And did you review documents that were  
19 produced in discovery that related to that?

20 A. I did.

21 Q. I'm going to show you a document marked  
22 Exhibit 84 to the Collier deposition, and if you can  
23 identify that, please, sir.

24 A. Yes. This is -- the report's entitled Key  
25 Operating Indicators for Woodridge Psychiatric

1 Hospital for the Period Ended June 30, 2014.

2 Q. And, Mr. Sullivan, your education and your  
3 graduate degree is an MBA?

4 A. It's an MHA, actually, Master's in Health  
5 Administration, but I took accounting courses and I  
6 sort of concentrated in finance in my program.

7 Q. And with your background and your experience,  
8 can you define what a concept called EBITDA is,  
9 E-B-I-T-D-A?

10 A. Yes. It's earnings before interest, taxes  
11 depreciation and amortization, so it's sort of a  
12 shorthand way of measuring cash flow. It's not a  
13 perfect measure, but it's used in the industry quite  
14 often as just a -- you take out a lot of the fixed  
15 expenses, like interest and depreciation, and then you  
16 just look at cash from operations.

17 Q. Can you identify in this exhibit EBITDA totals  
18 for Woodridge for the fiscal year ending June 30th,  
19 2014?

20 A. The EBITDA?

21 Q. EBITDA, yeah.

22 A. I'm sorry. It's on the first page. Well,  
23 it would be the net -- it's on the third page of this  
24 document. It would be the net operating income before  
25 support allocation. And then you would have to -- I'm

1 sorry. It's down at the bottom. I knew it was on  
2 here. I was just having a hard time spotting it.

3 EBITDA before support allocation in 2014 was  
4 \$3.4 million, roughly, and then it was 1.5 million  
5 after support allocations.

6 Q. And what is your understanding of what reports  
7 like this for Woodridge mean by support allocation?

8 A. That would be the overhead allocations that  
9 come from Mountain States. It would be the various  
10 services and expenses that are incurred at the  
11 corporate level that are stepped down to the  
12 individual operating entities.

13 Q. And for this year, this fiscal year, staying  
14 on that same page, can you identify the line item  
15 called "Total Increase in Unrestricted Net Assets"?

16 A. Yes. In this case, for fiscal year 2014, the  
17 bottom line increase in unrestricted net assets was  
18 \$99,000.

19 Q. And what was the net operating income before  
20 support allocation?

21 A. It was \$2.2 million, roughly.

22 MR. WEST: Your Honor, I'd like to move  
23 this document into evidence. It's already been marked  
24 as 84 to the Collier deposition.

25 THE COURT: Exhibit 84 will be marked Key

1 Operating Indicators regarding Woodridge Psychiatric  
2 Hospital for the Period Ending June 30th, 2014.

3 (Marked Exhibit No. 84.)

4 BY MR. WEST:

5 Q. All right. Mr. Sullivan, I have another  
6 document. This is MSHA document 1905 that has been  
7 marked as Exhibit 5 from the Collier deposition. I  
8 wanted to ask if you could identify that one, please.

9 A. Yes. This is a document very similar to  
10 the one we just looked at, but this is Woodridge  
11 Psychiatric Hospital key operating indicators, and  
12 this is for the period ending May 31st, 2015, so it's  
13 an 11-month later picture of the operations of  
14 Woodridge.

15 Q. And on the second page of the document -- the  
16 first page just identifies the MSHA number -- what is  
17 the 11-month year-to-date average daily occupancy  
18 percentage?

19 A. It is 85 percent.

20 Q. And the average daily census is what?

21 A. 71 patients.

22 Q. All right. And if you look on the second  
23 page, at the bottom, what is the EBITDA for this  
24 11-month period prior to the support allocation?

25 A. \$1.6 million.

1 MR. WEST: Your Honor, if I may, I'd like  
2 to make this Exhibit 85. It's been premarked.

3 THE COURT: Exhibit 85 will be marked Key  
4 Operating Indicators for the Period Ended May 31,  
5 2013, at Woodridge Psychiatric Hospital.

6 (Marked Exhibit No. 85.)

7 BY MR. WEST:

8 Q. Mr. Sullivan, I'm going to show you next a  
9 document that's been marked as Exhibit 87 to the  
10 Collier deposition. It bears the title Supplemental  
11 Exhibit H. Have you seen this document before?

12 A. I have.

13 Q. And was it produced in discovery in this  
14 matter?

15 A. It was.

16 Q. What does this document appear to you to  
17 cover?

18 A. It's showing patient days for four of the  
19 psychiatric units at Woodridge Hospital from the  
20 period -- and it doesn't say this on here, but  
21 covering the period September through June. I'm  
22 trying to recall. I believe this was 2015, but I'm  
23 not positive.

24 Q. But it was covered in the Collier  
25 deposition --

1 A. It was.

2 Q. -- and it was made an exhibit there.

3 And to the extent that these designations  
4 of the units completely cover -- let me put it this  
5 way: For any of the units covered by this chart for a  
6 particular month, what would be the -- how would you  
7 calculate the occupancy for that particular unit,  
8 like, for example, take Willow with 12 beds.

9 A. Sure. If you took September on this chart of  
10 293, you would divide the 293 by the number of months  
11 -- I mean, number of days in September, which would be  
12 30, and you'd get an average daily census. And then  
13 you would divide the average daily census by the 12  
14 beds in the Willow Unit.

15 Q. Well, couldn't you also simply assume that if  
16 there are 30 days in September and you have 12 beds,  
17 you could just multiply the 12 by 30 and get a total  
18 number of beds that are possible to be filled?

19 A. It's the same calculation just approached a  
20 different way.

21 Q. Okay.

22 MR. WEST: Your Honor, I'd like to make  
23 this the next exhibit, if I may, Number 87. It's been  
24 premarked.

25 THE COURT: Exhibit 87 is a document that

1 states "Woodridge Inpatient Days by Unit." It shows  
2 from September through June. It doesn't list a year.  
3 Mr. Sullivan says 2015.

4 Counsel, do you-all agree?

5 MR. SWEARINGEN: We don't have any  
6 disagreement with that, Your Honor.

7 THE COURT: For 2015.

8 (Marked Exhibit No. 87.)

9 BY MR. WEST:

10 Q. Mr. Sullivan, in your report, I believe it's  
11 Exhibit 8, is a reference to an article that you  
12 included as an exhibit by Eileen Salinsky and  
13 Christopher Loftis. Do you remember that.

14 A. I do.

15 Q. And I'm going to ask if you can -- this has  
16 been marked as your Exhibit 8. It's got the cover  
17 sheet from your report on it. I'd ask if you can  
18 identify this document.

19 A. Yes. This is a report that I reviewed and  
20 discussed in my report.

21 Q. And what does this report concern?

22 A. You know, many of the documents in my report  
23 talk about the decline in the number of public  
24 psychiatric beds. And this report talks a bit about  
25 the decline in the number of private psychiatric beds,

1 and it talks about some of the reasons why those  
2 changes have occurred, and it talked about -- you  
3 know, the general philosophy in the industry is you  
4 want to use the least restrictive setting for patients  
5 and hospitalization is kind of a last resort.

6 But it also mentions that the community-based  
7 resources that are supposed to fill the gap, you know,  
8 for patients who aren't being treated in an inpatient  
9 setting, primarily in a public setting, have really  
10 fallen short and haven't really picked up on the care  
11 of these patients to the extent that, you know, the  
12 patients are getting the necessary care for their  
13 illnesses.

14 And so I think this is just further indication  
15 that while community-based programs are good, they're  
16 not sufficient in and of themselves to address all the  
17 needs of the population.

18 Q. And who published this article? I mean, what  
19 entity published the article?

20 A. This was published by the National Health  
21 Policy Forum. It's under the auspices of the George  
22 Washington University.

23 Q. And as an expert witness in this area, do you  
24 consult documents like this in carrying out your  
25 analyses?

1 A. I do.

2 Q. And you used it in this case; is that correct?

3 A. I did.

4 MR. WEST: Your Honor, if I may, I'd like  
5 to make it the next exhibit.

6 MR. JACKSON: Your Honor, I do want to  
7 lodge an objection. Again, it's a hearsay document.  
8 It's been relied on by him, but just because an expert  
9 reviews something doesn't mean the whole document  
10 itself comes into evidence. This paper says many,  
11 many things, which I'm sure if we took the time to  
12 examine Mr. Sullivan about it, he doesn't know whether  
13 it's true or not. They may or may not be germane to  
14 his opinions.

15 I mean, this is just a whole bunch  
16 of opinions of some third party that are being  
17 interjected in the proceeding as an exhibit. Again,  
18 it's not to say he can't review materials and comment  
19 and rely on some aspects of it, but just to exhibit  
20 the whole article into our proceedings, I think, is  
21 not permissible and we would object.

22 MR. WEST: Your Honor, if I may, in  
23 their pretrial filings, they produced an article and  
24 attached it and served it on us that -- of a related  
25 nature, and so Mr. Sullivan had already cited this one

1 and utilized it in his report. And I don't see any --  
2 it's cited as authority as published by the George  
3 Washington University.

4 And this is the kind of information, the  
5 kind of document that experts in his position utilize,  
6 and our opponents have cited similar and sent copies  
7 to us of similar documents. So I would assert that we  
8 could at least get it into the record. The Court may  
9 give it such weight as it deems appropriate, but I  
10 think it forms a backdrop and gives context to his  
11 report.

12 THE COURT: I think under Rule 703 it  
13 is admissible. You didn't give me any basis to find  
14 any lack of trustworthiness. Certainly you can  
15 cross-examine the witness about it if there's areas  
16 that you think may not apply or that he should have  
17 reviewed and he didn't or whatever you think may be  
18 at issue.

19 What exhibit number would that be?

20 MR. WEST: 247.

21 THE COURT: Exhibit 247 will be marked a  
22 report entitled Shrinking Inpatient Psychiatric  
23 Capacity, Cause for Celebration or Concern. It has a  
24 National Health Policy Forum listed on it as well as  
25 George Washington University, has the date of August

1 1st, 2007.

2 (Marked Exhibit No. 247.)

3 MR. WEST: Your Honor, I'd like to  
4 suggest a short break. I believe I'm just about done,  
5 if not fully done, with our direct examination of  
6 Mr. Sullivan. It will give me an opportunity to  
7 consult with Mr. Grant to see if I need to ask  
8 anything further before I turn him over to  
9 cross-examination.

10 THE COURT: Okay. That will be fine.  
11 We'll take a short break.

12 (Recess observed.)

13 BY MR. WEST:

14 Q. Mr. Sullivan, I had one other matter I wanted  
15 to ask you about. In the course of preparing for this  
16 hearing, have you had an opportunity to examine any  
17 documents from the Department of Mental Health and  
18 Substance Abuse Services about any audits they've  
19 done?

20 A. Yes. I did review a recent audit they  
21 prepared. It was published on their website.

22 MR. WEST: And I don't have extra copies,  
23 Your Honor, but we did provide copies to opposing  
24 counsel. It's document number -- Exhibit Number 209.

25 MR. JACKSON: Your Honor, I don't know

1 what testimony is about to be elicited, but there's  
2 nothing in his report about this topic that I can  
3 recall, nor has this been disclosed prior to this  
4 minute that this witness was going to testify about  
5 whatever this is.

6 MR. WEST: Your Honor, this is a public  
7 document issued by the comptroller's office of the  
8 State of Tennessee. It's on their website. This is  
9 not -- it was not utilized, as I understand it, by  
10 Mr. Sullivan in preparing his report, but it is a  
11 public document issued by the -- concerning the Mental  
12 Health and Substance Abuse Services department.

13 And I think as a public document I'm  
14 entitled to ask this witness to identify it, because  
15 he's seen it before, and to enter it into the record  
16 in support of our position and his position, although  
17 he didn't review it in completing his report.

18 MR. JACKSON: Your Honor, I just don't  
19 think that's a proper basis to introduce an exhibit.  
20 If he didn't review it -- and he didn't review it --  
21 or cite it in his report or rely on it, then he's not  
22 the proper witness to authenticate it, which I guess  
23 is what's being offered, and it's just not proper.

24 THE COURT: Well, I guess I'm a little  
25 confused on how you're trying to use this. Because

1 certainly if he's offering any facts or opinions,  
2 opposing counsel is entitled to know what they are,  
3 even if they're late-developing. You have a duty  
4 to seasonally supplement your responses, which would  
5 be -- I'm assuming a Rule 26 interrogatory was served  
6 as well as a deposition. So if it's something that  
7 hasn't already been disclosed --

8 MR. WEST: Well, Your Honor, what I will  
9 do, then, is withdraw the question to Mr. Sullivan and  
10 reserve it for someone else.

11 THE COURT: Okay.

12 MR. JACKSON: Thank you, Your Honor.

13 MR. WEST: I believe that's all the  
14 questions I have for Mr. Sullivan at this time.

15 THE COURT: Okay. Cross-examination.

16 MR. JACKSON: Thank you, Your Honor.

17 CROSS-EXAMINATION

18 BY MR. JACKSON:

19 Q. Good afternoon, Mr. Sullivan.

20 A. Good afternoon.

21 Q. Good to see you again.

22 A. You too.

23 Q. We've covered a lot of ground today and I'm  
24 going to try and be as organized as I can in talking  
25 with you this afternoon. You'll forgive me if I move

1 around from time to time.

2 A. That's fine.

3 Q. One of the things you do as a health care  
4 consultant, obviously, is you prepare reports for  
5 CON-contested cases and you come and testify like  
6 you're doing here today, true?

7 A. Sure. Sure.

8 Q. But that's not all you do, right?

9 A. Right.

10 Q. You also provide clients with assistance in  
11 planning health care facilities, true?

12 A. I do.

13 Q. And you help, and have helped in the past,  
14 clients decide whether a project is needed from a  
15 health planning perspective?

16 A. True.

17 Q. And you've helped clients decide what size a  
18 project needs to be, right?

19 A. Yes.

20 Q. And you've done that kind of consulting over  
21 the course of years, many years that you've been  
22 working as a consultant, on many occasions, right?

23 A. That's correct.

24 Q. And at your deposition we had the  
25 opportunity to talk about some of the steps that you,

1 Mr. Sullivan, take when you're given that kind of  
2 engagement. Do you remember our discussion?

3 A. I do.

4 Q. And you told me that you have certain steps  
5 that you always perform when you're asked to do that  
6 kind of engagement, true?

7 A. That's true.

8 Q. And I've prepared a slide. I'm determined to  
9 use this elaborate equipment we brought with us, so  
10 here's my first effort to do so. I've prepared a  
11 slide for you, Mr. Sullivan, where I went through your  
12 testimony, and I'm going to ask you about each of the  
13 elements that you told me about. I'm going to project  
14 them up here so we can all follow along. Is that  
15 okay?

16 A. That's fine.

17 Q. You told me the first thing you do in this  
18 task is identify and consider the location of existing  
19 providers. Do you remember that?

20 A. I do.

21 Q. And then you said you do -- for the next step,  
22 if a provider doesn't already offer services in the  
23 area, you look for a surrogate facility to help you  
24 identify a service area, right?

25 A. Yes.

1 MR. WEST: Your Honor, I don't mean to  
2 impose an objection, but I would ask if we could see  
3 some citations to -- or hear some citations to the  
4 deposition pages that are being referred to.

5 MR. JACKSON: Well, Your Honor, I --  
6 BY MR. JACKSON:

7 Q. Forget about the deposition. Let's just talk  
8 about you here today. That's a step you take, right?

9 A. Yes.

10 Q. And another step you take is that you evaluate  
11 the population numbers of the area, right?

12 A. Yes.

13 Q. And the next step you do after that is you  
14 look at the use rates per capita in terms of -- use  
15 per capita, sorry, and that may be in terms of either  
16 use rates, if those are available, right?

17 A. Right.

18 Q. Or it may be in terms of one of these bed  
19 formulas like beds per 1,000 we've been talking  
20 about -- or 100,000, right?

21 A. That's correct.

22 Q. And then you told me that the next thing you  
23 do -- or the next thing you would do if you were asked  
24 by a client to decide whether a new facility was  
25 needed was you would evaluate services being offered

1 by the competition, true?

2 A. Yes.

3 Q. You would evaluate road access among the  
4 various providers, right?

5 A. Yes.

6 Q. You would evaluate the demographics, including  
7 the income levels; that would be something you'd be  
8 interested in too, right?

9 A. Yes.

10 Q. Then, after you've assembled all of this  
11 information, you would develop projections of total  
12 market demand for services, right?

13 A. Yes.

14 Q. And that would be in whatever area you're  
15 studying, the total demand for, say, psychiatric  
16 services in that area, right?

17 A. Yes.

18 Q. Then the next thing you would do would be to  
19 come up with an estimate of a reasonable market share  
20 that the new provider might capture, right?

21 A. Yes.

22 Q. So, for example -- and this is just an  
23 example. If you have -- if you've projected 1,000  
24 discharges in psychiatry in this area, you might say  
25 new provider -- client new provider could capture

1 40 percent of those, reasonably, right?

2 A. Sure.

3 Q. And then you would take that number, then,  
4 and base the size of the facility that you're opining  
5 about for your client on the basis of the market share  
6 that you think could reasonably be captured, true?

7 A. Right. Yeah. Sometimes I might do a range,  
8 but, yeah, you would look at projected range of market  
9 share and then projected facility size based on those  
10 assumptions.

11 Q. Right. And it's not an exact science.  
12 There's an art to this, right?

13 A. Yes.

14 Q. But you do come up with these -- a range, your  
15 best estimate of what the market share is going to be,  
16 and you apply it against the total market share and  
17 the population, right?

18 A. Yes.

19 Q. And then you take that and project a target  
20 daily census, right? You use those volumes?

21 A. Yes.

22 Q. And that's the steps you take when you are  
23 asked to do this, Mr. Sullivan, as a health care  
24 consultant, for a client considering a new enterprise,  
25 true?

1 A. Yes.

2 Q. And after you've done all of that, you have  
3 the answer, don't you, to the question is there a need  
4 for this new facility and how big should it be, right?

5 A. Yes.

6 Q. And, of course, in this case, you were  
7 retained well after the CON application had been  
8 filed, true?

9 A. True.

10 Q. You had no involvement at all in the  
11 decision-making process leading to the filing of the  
12 CON?

13 A. I did not.

14 Q. You had no involvement at all in the decision  
15 by SBH to declare a service area of these two  
16 Tennessee counties and the three Virginia counties,  
17 true?

18 A. I was not involved.

19 Q. You didn't have any input into their decision  
20 to make this a 72-bed hospital, right?

21 A. I did not.

22 Q. Now, you had actually done work for SBH before  
23 this case, right?

24 A. One previous time.

25 Q. Right. They had come to you and asked for

1 your advice about some stuff they had going on in  
2 Alabama?

3 A. Yes.

4 Q. And if they had called you and asked you for  
5 help in performing a need analysis for them, that's  
6 something you would have been willing to do if you had  
7 the time, right?

8 A. Sure.

9 Q. And you don't know today exactly what factors  
10 Mr. Garone or Mr. Shaheen and his colleagues may or  
11 may not have looked at to come up with the service  
12 area in this case, true?

13 A. I do not.

14 Q. As far as what analysis, planning, thought  
15 or methodology went into the selection of the service  
16 area before the filing of the CON, you don't know what  
17 those would be?

18 A. Other than what was described in the  
19 respective depositions of Mr. Shaheen and Mr. Garone.

20 Q. Right. And when you studied those  
21 depositions, you saw that they really had no analysis  
22 in writing of any kind, right, before they filed the  
23 CON application?

24 A. I think other than -- I think someone was  
25 calling the intern study -- there was a prior market

1 analysis done before the CON was prepared.

2 Q. And while we're on that subject, other than  
3 the CON application itself, you've never seen any  
4 document, spreadsheet, analysis, memorandum or study  
5 in which anyone associated with SBH has analyzed the  
6 need for inpatient psychiatric services in the service  
7 area identified in the application, true?

8 A. I've not seen a specific document.

9 Q. And you certainly haven't seen any written  
10 documentation where anybody at SBH, before the filing  
11 of the CON, went through all of these steps, true?

12 A. I have not.

13 Q. And you haven't seen any written documentation  
14 or written explanation of why this was selected to be  
15 a 72-bed hospital as opposed to a 52-bed hospital or a  
16 32-bed hospital, true?

17 A. I did not see that.

18 Q. You've never seen anything in writing that  
19 explains -- you know there's a pro forma, right?

20 A. Yes.

21 Q. And they've told you it was based on their  
22 experience, right?

23 A. Right.

24 Q. But other than knowing there's a pro forma and  
25 they say it's based on their experience, you don't

1 know how they came up with the admission numbers that  
2 are contained in the application, right?

3 A. Not specifically, other than based on their  
4 prior experience with opening new facilities.

5 Q. But as far as going back and looking and  
6 checking on that experience or validating any of that,  
7 you haven't done that, right?

8 A. I have not.

9 Q. Now, you don't know why they didn't include a  
10 residential component in this project, do you?

11 A. I don't.

12 Q. And you know residential for -- I don't know  
13 if it's come up in this case. What's the difference  
14 between a residential psychiatric bed and an acute  
15 psychiatric bed?

16 A. It's, I guess, two main differences. One is  
17 residential tends to be a lower level of care, so you  
18 have lower staffing levels, and it tends to be a  
19 longer term setting for patients, so patients who  
20 need long-term placement and therapy in order to --  
21 particularly for patients that have severe mental  
22 health disorders.

23 Q. And you know that SBH, at some of its other  
24 facilities, for example, in North Carolina, they have  
25 residential beds, right?

1 A. That's true.

2 Q. And you would agree that's a service that's  
3 actually needed in Upper East Tennessee, right?

4 A. Among many, yes.

5 Q. And you don't know why this company decided,  
6 instead of doing that, putting in residential beds,  
7 they decided to do acute care beds? You've never seen  
8 where they've explained that in writing anywhere,  
9 right?

10 A. I've not seen any specific discussion about  
11 residential beds in this particular location.

12 Q. Now, when we talk about health planning  
13 generally, when we talk about these different kinds  
14 of beds, let's see if we can agree that in health  
15 planning, some resources are best disbursed throughout  
16 the community, if you will, so that -- and then there  
17 are other health care resources that are more usually  
18 centralized. Is that a fair statement?

19 A. Yes. I mean, I think some things are so  
20 basic that you want to have those readily accessible  
21 to the population; other things, where the level of  
22 demand may be smaller, you'd want to centralize in  
23 order to have economies and quality of care.

24 Q. And, for example, we would agree that maybe  
25 imaging centers with, you know, x-rays and CT scans

1 and MRIs, that's something that would be more of a  
2 local service, right?

3 A. Sure. High volume, pretty basic, it could be  
4 done with minimal fuss. Yes.

5 Q. And when I say local basis, that means there  
6 will be more providers scattered around in smaller  
7 towns, and what have you, so that people don't have  
8 to go a long way to access those services, right?

9 A. That's true.

10 Q. And dialysis would be another such service,  
11 right?

12 A. Sure.

13 Q. Community care hospital beds, meaning acute  
14 care beds, those are more localized too, aren't they?

15 A. Sure. And particularly as it relates to  
16 emergency services, you want to make sure that those  
17 are readily accessible to the population.

18 Q. And usually -- there are a few freestanding  
19 ERs, not that many, but there are some. But usually  
20 when you have an emergency department in a smaller  
21 town, you also have some medical/surgical beds, right?  
22 Those are sort of generic hospital beds, right?

23 A. True.

24 Q. And they treat things like pneumonia or the  
25 flu or whatever -- broken legs, whatever things people

1 come in for, right?

2 A. Yes.

3 Q. And obviously, if it's a higher acuity problem  
4 or more complex problem, then those people often get  
5 transferred to a tertiary care center, right?

6 A. That's true.

7 Q. You would agree, wouldn't you, Mr. Sullivan,  
8 that a psychiatric hospital, a psychiatric inpatient  
9 bed, that's more of a regional service than it is a  
10 local service, fair?

11 A. Fair. You know, I think it varies a little  
12 bit by the age category of the patients. For example,  
13 geriatric psychiatry, because that population has a  
14 hard time traveling, you probably want to have those  
15 services perhaps be a little more decentralized. But  
16 for other types, I would agree, for adult and  
17 particularly for child and adolescent, somewhat more  
18 regionalized.

19 Q. And I think we mentioned in your deposition,  
20 there are 95 counties in Tennessee. Maybe there's,  
21 you believe, fewer than 15 freestanding psychiatric  
22 hospitals, true?

23 A. Yes.

24 Q. And earlier today you were talking about child  
25 and adolescent beds. That's something that you agree

1 is a centralized service, right?

2 A. Yeah. I mean, just by the nature of how the  
3 system has evolved, there's relatively few of those  
4 located in Tennessee and many other states as well.

5 Q. And by the way, while I'm thinking about it,  
6 you suggested to us earlier that people who couldn't  
7 get into a child and adolescent bed in Johnson City  
8 would have to go to Nashville. Do you remember that?  
9 I'm sorry, or Chattanooga maybe. I think you said  
10 Nashville. You said going west the closest bed was  
11 Nashville, right?

12 A. I think that's right.

13 Q. But you know, don't you, there are 35 child  
14 and adolescent beds at Peninsula Hospital in  
15 Knoxville, right?

16 A. There are.

17 Q. So you would agree that the most likely place  
18 that a child who couldn't get placed for whatever  
19 reason at Woodridge in Johnson City would just drive  
20 down the road an hour or so to the hospital at  
21 Peninsula, right?

22 A. To the extent they have availability, yes.

23 Q. Okay. Now, when you're determining a service  
24 area as a provider for a project, what you do is sit  
25 down and try to figure out where the patients are

1 going to come from, basically, right?

2 A. Right.

3 Q. And you use data to do that, right?

4 A. I do.

5 Q. And if it's an existing provider, as we  
6 mentioned earlier, you'll look at their history, and  
7 if it's a new provider, you'll try and come up with a  
8 surrogate facility, right?

9 A. Yes.

10 Q. And I think you've told us that the total  
11 service area of a health care facility is where about  
12 90 percent of the patients come from, right?

13 A. True.

14 Q. And for health planning purposes, sometimes  
15 you and others like you divide the total service area  
16 into primary and secondary service areas, right?

17 A. Pretty typical, yes.

18 Q. Although that is, isn't it, a matter of  
19 convention among health planners? It's not reflected  
20 in the statutes or laws of Tennessee, true?

21 A. Right. In my review of the other psychiatric  
22 applications that have been recently approved, the  
23 service area that they've used for purposes of need  
24 determination appear to be the primary service area,  
25 not the total service area.

1 Q. Right. I'm just simply making sure we agree  
2 that that's a distinction that's not actually  
3 technically in the rules and regulations, right?

4 A. That's true.

5 Q. And the primary service area, I think you told  
6 us earlier today, is one where 75 or 80 percent of  
7 your patients are coming from, right?

8 A. True.

9 Q. And you know, don't you, that the state  
10 Department of Mental Health in Tennessee divides our  
11 state into several catchment areas for psychiatric  
12 services, right?

13 A. True.

14 Q. And the Tri-Cities, all of the Tri-Cities are  
15 in the same region, right?

16 A. I think Region 1.

17 Q. And Region 1 is a 24-county region, right?

18 A. That's correct.

19 Q. And it includes both Sullivan and Washington  
20 County, true?

21 A. True.

22 Q. And you know Lakeshore, the hospital we talked  
23 a lot about that's closed now, that was in Knoxville,  
24 right?

25 A. Sure.

1 Q. You know it had a service area that was  
2 24 counties as well, right?

3 A. It paralleled the regions that the mental  
4 health department defines.

5 Q. So it served both Washington and Sullivan  
6 counties, true?

7 A. True.

8 Q. And you know that people living in Sullivan  
9 County today account for about 25 percent of the  
10 patients being seen at Woodridge in Johnson City,  
11 true?

12 A. Based on the data I've seen, that's correct.

13 Q. And based on that, we could agree, I think,  
14 that Sullivan County would certainly fit into the  
15 primary service area of Woodridge as you define  
16 primary service area, true?

17 A. I would agree with that.

18 Q. And after you were hired -- and I think it  
19 came up briefly in your testimony, and I know you  
20 mentioned it in your report -- after you were hired in  
21 this case, Mr. West sent you an HCA application from  
22 20-some years ago relating to a community hospital in  
23 Kingsport. Do you remember that?

24 A. Yes.

25 Q. And that application of that Kingsport

1 hospital didn't include Washington County in the  
2 service area, right?

3 A. It did not.

4 Q. Other than that one application that Mr. West  
5 sent you from 20 years ago, do you know any other CON  
6 application where any Kingsport providers ever  
7 projected a service area that does not include  
8 Washington County?

9 A. I've not reviewed all of those CONs, so I'm  
10 not sure.

11 Q. Well, as far as you know, though, you haven't  
12 seen one, right?

13 A. I'm not sure why they would based on my  
14 empirical analysis of their historical patient origin,  
15 but I can't say one way or the other.

16 Q. And, of course, you know that in the  
17 relatively recent past, in Kingsport, there was this  
18 psychiatric facility, the Indian Path Psychiatric  
19 Pavilion, right?

20 A. I do.

21 Q. And that's the one that closed, I think, in  
22 2009; is that right?

23 A. True.

24 Q. And just for point of reference, I've got a  
25 map here.

1 MR. JACKSON: And I've actually got an  
2 exhibit on this, Your Honor.

3 BY MR. JACKSON:

4 Q. You'll see in the map that I have -- you'll  
5 see on the exhibit --

6 MR. JACKSON: Your Honor, may approach?

7 THE COURT: Yes.

8 BY MR. JACKSON:

9 Q. We've marked as Exhibit 376 a small version  
10 of this map, Mr. Sullivan, and you'll see that it  
11 demonstrates the relative locations of the Indian Path  
12 Medical Center and its psychiatric pavilion that  
13 formerly existed and this proposed new hospital, true?

14 A. Yes.

15 Q. And we can agree they're less than a mile  
16 apart as the crow flies and really just right down the  
17 street?

18 A. .7 miles, it looks like.

19 Q. All right. Now, in your report --

20 MR. JACKSON: Your Honor, I would move  
21 376 into evidence.

22 THE COURT: Exhibit 376 will be marked.  
23 It is a map that shows the location of Indian Path  
24 Pavilion and the proposed SBH facility.

25 (Marked Exhibit No. 376.)

1 BY MR. JACKSON:

2 Q. Now, in your report in this case, you did not  
3 analyze the psychiatric discharges from Indian Path  
4 Pavilion to see where the patients came from, true?

5 A. I did not.

6 Q. And you know that Dr. Collier did do that in  
7 her report, right?

8 A. I'm aware of that.

9 Q. And I've put up, from her report -- this is  
10 Map 3, and this will be introduced into evidence later  
11 when Dr. Collier testifies, but we can agree that  
12 looking at the -- can you see that okay?

13 A. I can.

14 Q. Okay. Looking at the upper right-hand box  
15 there, the Number 1 source of psychiatric patients in  
16 Indian Path for the last three years of its operation  
17 was, not surprisingly, Sullivan County, right?

18 A. Right.

19 Q. And you will agree, won't you, Mr. Sullivan,  
20 that the second most common county of origin for  
21 psychiatric patients being seen at the only  
22 psychiatric hospital in Kingsport at the time was  
23 Washington County, true?

24 A. Sure. I mean, that was a different time and a  
25 different competitive marketplace.

1 Q. Well, it was, to be fair, the only time in  
2 recent history that there's been a psychiatric  
3 hospital in Kingsport, right?

4 A. That's true.

5 Q. And you would agree that based on these  
6 numbers you would include Washington County in the  
7 primary service area of Indian Path Psychiatric  
8 Pavilion at the time, right?

9 A. I would have at that time.

10 Q. Okay. Lee County, that's that -- you know Lee  
11 County is in Virginia, right?

12 A. Correct.

13 Q. And it's one of the counties that's been --  
14 three Virginia counties that's claimed as the service  
15 area of this hospital, right?

16 A. True.

17 Q. And it's not shaded in on this map, but it  
18 would be the county right to the left of -- or west of  
19 Scott County, right?

20 A. Yes.

21 Q. And you see, don't you, that Lee County  
22 accounted for -- it's not even on the chart, right?

23 A. Right.

24 Q. And that means it accounted for fewer than  
25 51 admissions, which is 2.5 percent. That's the

1 lowest number on there. And so, presumably, if  
2 anybody came from Lee County to Kingsport for  
3 psychiatric care from 2007 to 2009, it was fewer  
4 than 51 people, right?

5 A. I would assume that's correct.

6 Q. Have you seen or performed, yourself, any  
7 written analysis showing how this new SBH hospital  
8 is going to draw more patients from Lee County up in  
9 the mountains of Virginia than it is from Washington  
10 County which is located right next door with an  
11 interstate connecting the two?

12 A. I've not done any written analysis of that.

13 Q. Have you seen anything anybody else has done  
14 to explain why this hospital should have, in its  
15 service area, that Lee County -- by the way, there's  
16 about, what, 25,000 people in Lee County?

17 A. It's not a large county.

18 Q. And it is over the mountains, right?

19 A. It is.

20 Q. And Washington County has, what, 150,000  
21 people in it?

22 A. I think it's about 120 maybe.

23 Q. And there's no mountain range between the two,  
24 right?

25 A. There's not.

1 Q. And there's an interstate highway, in fact,  
2 right?

3 A. There is.

4 Q. Have you seen anything where the folks at SBH  
5 have analyzed or explained why their primary service  
6 area includes this Lee County with the 25,000 people  
7 over the mountains but excludes Washington County with  
8 150,000 people connected by interstate?

9 A. Have I seen anything written?

10 Q. Yes, sir.

11 A. I have not.

12 Q. And you know that the drive time from the new  
13 hospital proposed site and Kingsport, you can drive  
14 from there to the Washington County line in, what,  
15 ten minutes?

16 A. I don't know the exact time, but it depends on  
17 what part of the county you're starting in and what  
18 part of the county line you're going to, but it's  
19 probably in the range of 10 miles or 12 miles.

20 Q. Right. Because you can drive all the way from  
21 Kingsport to Johnson City, to the actual doorstep of  
22 the medical center, in about 25 to 30 minutes, right?

23 A. Yeah. I think I saw 29 minutes on one chart.

24 Q. Okay. So you can certainly make it to the  
25 Washington County line -- by the way, you didn't

1 do any kind of analysis of where people live in  
2 Washington County, did you, population center?

3 A. In Washington County?

4 Q. Yes, sir.

5 A. No. I mean, I know that Johnson City is the  
6 largest single population center in the county, but I  
7 didn't do any analysis beyond that.

8 Q. All right. Because there will be some people,  
9 though, that live near the Washington/Sullivan line,  
10 right?

11 A. Sure.

12 Q. And you haven't done any analysis to figure  
13 out how many hundreds of thousands of people that may  
14 be, true?

15 A. Well, I'm sure it's not hundreds of thousands.

16 Q. Hundreds or thousands. Sorry.

17 A. I have not.

18 Q. Okay. And do you know how long it's going to  
19 take someone to drive from the remote reaches of Lee  
20 County to the new hospital?

21 A. Probably be in excess of that time. It's --  
22 you know, I mean, the problem is that that population  
23 doesn't have a lot of access to psych services  
24 otherwise, and so those folks will have to drive a  
25 bit farther. But based on other data that I've seen,

1 patients from Lee County do come to Kingsport to  
2 receive other types of health care services.

3 Q. We can certainly agree that it will be much  
4 easier for the folks in Washington County to access  
5 this new hospital than it will be for the folks in Lee  
6 County, right?

7 A. Sure. But the folks in Lee County don't have  
8 an existing hospital.

9 Q. In Virginia?

10 A. In Virginia.

11 Q. When Indian Path Psychiatric Pavilion was  
12 operational, it also attracted more patients from  
13 Washington County than it did from Hawkins County,  
14 true?

15 A. It did.

16 Q. And SBH has included Hawkins County in its  
17 service area, but it's excluded Washington County,  
18 true?

19 A. That's true.

20 Q. When Indian Path Psychiatric Pavilion was  
21 operational, it drew almost four times more patients  
22 from Washington County than it did from Wise County,  
23 Virginia; isn't that correct?

24 A. Sure. I mean, Washington's a much larger  
25 county. And, again, those were different times with

1 different competitive landscapes.

2 Q. Well, they were different times, but these  
3 counties haven't really changed in relative size,  
4 right?

5 A. No. The population growth in the Virginia  
6 counties has been relatively modest.

7 Q. And just if I can jump out of line for a  
8 minute, since you mentioned population growth, the  
9 population of this area is not growing to an extent  
10 to generate any material new demand for psychiatric  
11 services anywhere in this region, true?

12 A. Other than the aging of the population is  
13 probably -- there's an increasing demand for geriatric  
14 psychiatry, but overall, the overall level of growth  
15 is only in the range of about 1 percent.

16 Q. Right. I mean, sometimes you have -- like  
17 Rutherford County -- you brought up the TrustPoint  
18 application earlier. Rutherford County is the fastest  
19 growing county in Tennessee and one of the fastest in  
20 the United States, right?

21 A. I don't know about the United States, but I  
22 know it's either the fastest or one of the fastest in  
23 Tennessee.

24 Q. Right. And by contrast, we can agree, can't  
25 we, that the population of the Tri-Cities is basically

1 flat?

2 A. Yeah. I think there's modest growth, I would  
3 describe it as.

4 Q. So we're back -- Wise County, I think we  
5 mentioned, you would agree Wise County has been  
6 included in the service area by SBH, right?

7 A. Right.

8 Q. But, again, Washington County, obviously it's  
9 out, right?

10 A. Right.

11 Q. Greene County, that's not included in the SBH  
12 service area either, is it?

13 A. It's not.

14 Q. Yet, you would agree, wouldn't you,  
15 Mr. Sullivan, that when the Indian Path Psychiatric  
16 Pavilion was open, Greene County accounted for more  
17 admissions to that facility than Wise County, right?

18 A. It did by a small margin.

19 Q. And certainly more than Lee County, as we've  
20 already covered, which is not even on the chart,  
21 right?

22 A. Yes.

23 Q. Now, one of the things the CON program is  
24 supposed to do, isn't it, Mr. Sullivan, is help ensure  
25 that people have good access to health care services,

1 right?

2 A. True.

3 Q. And one way of measuring access is through  
4 something called a drive-time analysis, true?

5 A. Sure.

6 Q. And for accessing inpatient -- well, let me  
7 back up.

8 In a drive-time analysis, we might say, for  
9 example, you need to have dialysis centers within  
10 30 minutes driving time of most of the population.  
11 Like, that would be an example of a drive-time  
12 standard, right?

13 A. Sure.

14 Q. And then you might say more advanced services  
15 you want to have within an hour and a half or whatever  
16 of a person's residence, right?

17 A. Yes.

18 Q. And this is a way just to sort of -- we  
19 understand and appreciate, don't we, that sometimes  
20 people have to drive a little further to get a more  
21 specialized service, and that's okay from a health  
22 planning perspective, right?

23 A. Yeah. You want to minimize the number of  
24 people that are driving the maximum distance.

25 Q. And for accessing inpatient psychiatric

1 services like we're here about, you would agree it's a  
2 reasonable planning standard for people to be within a  
3 one-hour drive of such facilities, true?

4 A. Sure. I mean, as an outside driving distance,  
5 yes. I mean, obviously you would want to improve  
6 access to the greatest extent that you could, but one  
7 hour being sort of the outside margin on that.

8 Q. And you know some states actually have  
9 formally adopted drive-time standards for psychiatric  
10 services, right?

11 A. They have.

12 Q. In fact, Virginia -- and Virginia, of course,  
13 is where three of these counties claimed in the  
14 service area are located. Virginia actually has a  
15 60-minute standard, doesn't it?

16 A. It does.

17 Q. And you know our own state, Tennessee -- you  
18 know about our TennCare program, of course?

19 A. I do.

20 Q. Let me hand you --

21 MR. JACKSON: If I may approach, Your  
22 Honor.

23 BY MR. JACKSON:

24 Q. -- Exhibit 321. I think I asked you. I don't  
25 think you'd actually seen this when you did your

1 report, right?

2 A. I had not.

3 Q. If you look at Page 2 of Exhibit 321, in  
4 Tennessee, the TennCare Bureau, in February 2015,  
5 set a geographic access requirement for psychiatric  
6 inpatient hospital service that travel distance does  
7 not exceed 90 miles for at least 90 percent of  
8 members, right?

9 A. I see that.

10 Q. And when it comes to the drive-time standards,  
11 you're not basing any of your opinions about need, as  
12 I understand it, on the idea that anyone in this  
13 service area has to drive too far, right?

14 A. Most of the population in Tennessee is within  
15 an hour of an existing psychiatric provider of some  
16 type. That's not true for all types of services. And  
17 by "too far," I'm not sure what you mean, but I think  
18 that, you know, the use rate analysis I talked about  
19 earlier shows that the distance from existing services  
20 does influence the utilization of those services.

21 Q. And I guess what I'm saying is when I looked  
22 at your report, I didn't see anywhere in your report  
23 where you expressed the opinion that these folks in  
24 this part of the service area are more than an hour  
25 away, therefore something's needed so they can be

1 within an hour, fair?

2 A. That's fair.

3 MR. JACKSON: Your Honor, I'd move 321 as  
4 the next exhibit, please.

5 THE COURT: Exhibit 321 will be marked.  
6 It is a TennCare Operational Protocol dated  
7 February 2015.

8 (Marked Exhibit No. 321.)

9 BY MR. JACKSON:

10 Q. And, Mr. Sullivan, just to follow up on one  
11 point, you mentioned a couple of times the changing  
12 competitive landscape, and I just want to make sure  
13 we can agree. There's been no other new psychiatric  
14 provider interjected into this region since Indian  
15 Path Psychiatric Pavilion closed, correct?

16 A. Correct. But what did change is that Indian  
17 Path was the major provider of psychiatric services  
18 back in the mid 2000s. And after Mountain States took  
19 them over, they began to shrink the operations of  
20 Indian Path and expand the operations of Woodridge.

21 And so where we sit today, Woodridge is a  
22 highly utilized 84-bed psychiatric hospital. In those  
23 days, it was a 75-bed lowly utilized hospital. And so  
24 that part of the competitive landscape has shifted.

25 Q. Right. But you still have the same provider

1 landscape in terms of number of providers, right?

2 A. We have one fewer provider.

3 Q. Right. The one we're talking about, right?

4 A. Yes.

5 Q. And when it was operational and when it was  
6 going full gangbusters, just like we expect the SBH  
7 facility to do, the second highest county of origin  
8 was people from Washington County, right?

9 A. Right. Because there wasn't a strong  
10 competitor in Washington County at that time.

11 Q. Well, I guess other than these, sort of,  
12 documents you put into your testimony at the end  
13 there, is there anywhere you've really analyzed the  
14 performance of Woodridge back when Indian Path was  
15 open, I mean, or are you just relying on those three  
16 pages of documents that were exhibited towards the end  
17 of your testimony?

18 A. Not just that. I recall in some of the  
19 deposition testimony, and it's been a while since  
20 I read it now, that Woodridge was not doing well  
21 financially at the time that Mountain States bought  
22 it from Frontier Health, and so a lot of resources  
23 hadn't been poured into that particular facility.

24 And so I'm relying on that as well, that it  
25 was a facility that was struggling, didn't have a lot

1 of resources. Mountain States took it over and  
2 made some sort of corporate decision that they were  
3 going to concentrate psych services at Woodridge and  
4 de-emphasize those services at Kingsport. That's what  
5 I know.

6 Q. Okay. We've talked about drive-time  
7 standards. Let me ask you something about another  
8 benchmark that's used to determine whether services  
9 are reasonably accessible, and that's use rate, right?

10 A. Yes.

11 Q. And you, yourself, have employed use rate  
12 analyses in other CON cases, like your Huntingdon  
13 case, right?

14 A. I did.

15 Q. And you've used it in the Huntingdon case as a  
16 proxy for access, right, an indicator for access?

17 A. Sure. Very low use rates in the Huntingdon  
18 area at the time of the application.

19 Q. And the low use rates meant to you there was a  
20 need for more beds, right?

21 A. Correct.

22 Q. And so low use rates equals poor access to  
23 beds, right?

24 A. Sure.

25 Q. And the converse is also true, right, higher

1 use rates equals better access, fair?

2 A. In general, yes.

3 Q. And you've seen Dr. Collier's analysis in this  
4 case where she looked at the use rate in Sullivan  
5 County, right?

6 A. Right.

7 Q. And it was higher than the average in the  
8 state of Tennessee, right?

9 A. Sure. Again, I don't agree that the average  
10 in the state of Tennessee is any kind of standard for  
11 access, but it is higher than the average.

12 Q. And, by the way, you said that you couldn't  
13 calculate use rate yourself, but isn't it true,  
14 Mr. Sullivan, that if you look at her report, at  
15 Page 26 specifically, she makes it clear that she  
16 calculated these use rates using joint annual reports,  
17 right?

18 A. I'm not sure how she could capture all of the  
19 patients using joint annual reports.

20 Q. Well, I guess we'll ask her about that, but  
21 let me ask you: Did you try and calculate a use rate  
22 using joint annual reports?

23 A. I looked at the utilization that I could  
24 capture looking at the joint annual reports, but I  
25 wasn't confident that that would be an effective way

1 to calculate use rates.

2 Q. You talked earlier today as Washington  
3 County's being higher, and that's because there's  
4 better access there, right?

5 A. Yes.

6 Q. You did note, though, didn't you, that in 2012  
7 Unicoi County actually had the highest use rate of  
8 all, right?

9 A. Sure. I mean, a small county, a few patients  
10 can swing the use rate quite a bit, you know, and so I  
11 tend to take those kinds of rates in small counties  
12 with a grain of salt, but in a larger county, I would  
13 -- that would be meaningful.

14 Q. Sure. In fairness, several of these counties  
15 we're talking about are fairly small counties, right?

16 A. They are.

17 Q. And the numbers, therefore, of people getting  
18 admitted to psychiatric hospitals are small, right?

19 A. Generally.

20 Q. Relatively speaking?

21 A. Yes.

22 Q. And so a change of just a few patients can  
23 move the use rate around in kind of a dramatic  
24 fashion, right?

25 A. Sure.

1 Q. Now, another indicator of poor access to  
2 health care facilities can be something we call  
3 out-migration, right?

4 A. Sure.

5 Q. And out-migration refers to people leaving a  
6 particular area and going to another -- another area  
7 for medical care, right?

8 A. Right.

9 Q. And that's really what you've spent a lot of  
10 time today talking about is this idea that people are  
11 going all over the place because there aren't enough  
12 beds at Woodridge, right?

13 A. Sure.

14 Q. And we actually have data on this. I don't  
15 think you talk about it in your report, but if you  
16 look at the application that was filed in this case  
17 that's been made Exhibit 9, at Page 12 this actually  
18 tells us, doesn't it, who is leaving the claimed  
19 service area and where they're going, right?

20 A. This is the staff report from the HSDA?

21 Q. Yes, sir.

22 A. Okay. Yes.

23 Q. If we look at this -- first of all, there can  
24 be a lot of reasons why someone leaves the area for  
25 treatment, right?

1 A. Sure.

2 Q. I mean, one idea that you've already suggested  
3 today is because there's no room at the inn and the  
4 beds are all full, right, that's one reason?

5 A. That would be one.

6 Q. Another reason may be someone has ties to  
7 another community and they go there for treatment,  
8 right?

9 A. Yes.

10 Q. Another may be they're seeking specialized  
11 types of treatment that aren't available in the local  
12 community, right?

13 A. Sure.

14 Q. They may have insurance issues, you know,  
15 someone's out of network, and if they go down to  
16 another town, they can get a better deal on their  
17 insurance, right?

18 A. Possibility, yes.

19 Q. And so when we look at these numbers, we have  
20 to take into account, don't we, that people aren't all  
21 leaving for the same reason, right?

22 A. Sure. There are a number of reasons.

23 Q. And if we study the number that's in the CON  
24 summary report, we see, first of all, leaving the  
25 defined service area --

1 MR. JACKSON: Is there any way to sharpen  
2 that a little? I think it just needs focusing a  
3 little bit.

4 Your Honor, it's also in your notebook,  
5 Exhibit 9, Page 12. I was hoping this would be easier  
6 to look at it up there.

7 That's better. That is better. I  
8 thought I was losing my vision.

9 BY MR. JACKSON,

10 Q. We see, first of all, leaving this defined  
11 service area, these two counties in Tennessee and  
12 three counties in -- two counties in Tennessee, we  
13 have 1,125 people going to Woodridge, right?

14 A. Yes.

15 Q. And then if we look over to look at who else  
16 is out-migrating, we see we had a total of six  
17 patients going to Vanderbilt in Nashville, right?

18 A. Yes.

19 Q. All adults, right?

20 A. Yes.

21 Q. And, of course, Vanderbilt Psychiatric  
22 Hospital has a higher level of services than is  
23 available in East Tennessee, right?

24 A. I don't know the answer to that.

25 Q. Okay. Nobody is indicated to have gone to

1 Memphis, right?

2 A. Not in this chart, no.

3 Q. And you've never -- and you've looked at a lot  
4 of data in this case. You've never seen any evidence  
5 anybody has ever gone to Memphis for psychiatric care  
6 from the Tri-Cities, right?

7 A. Yeah. I have not seen any documentation of  
8 that.

9 Q. Okay. The only substantial out-migration in  
10 this chart to any facility other than to Woodridge was  
11 to Knoxville's Peninsula, right?

12 A. Right.

13 Q. And that was a total of 239 cases; is that  
14 right?

15 A. Correct.

16 Q. Now, you know that the SBH hospital is  
17 projected to have 2,000 cases, approximately, by  
18 Year 2, right?

19 A. 1,859, but yes.

20 Q. All right. Close enough. And that's  
21 assuming, again, a 62 percent occupancy, right?

22 A. Yes.

23 Q. So you would agree, wouldn't you,  
24 Mr. Sullivan, that even if 100 percent of these  
25 patients who left the area for whatever reason to

1 go to Peninsula Hospital an hour or so way down in  
2 Knoxville decided to go instead to the new hospital,  
3 that would be 239 cases out of 1,859 cases, right?

4 A. I mean, approximately, but there's a number of  
5 other hospitals. I mean, like Moccasin Bend. I don't  
6 know to what extent those patients would stay home.

7 Q. And Moccasin Bend, there were 42 people that  
8 went from this part of East Tennessee down to Hamilton  
9 County, right?

10 A. Correct.

11 Q. And, by the way, the Peninsula people, you  
12 know that Peninsula is another hospital that, like  
13 Woodridge, has agreed to take state patients, right?

14 A. Right. I think there were three that had  
15 agreed to do that.

16 Q. And so you don't know or haven't done an  
17 analysis to figure out how many of these 239 patients  
18 might be state patients, that is, uninsured people,  
19 indigent people, right?

20 A. I don't know.

21 Q. And while I'm thinking about that topic,  
22 Mr. Sullivan, we've talked a lot today, and you've  
23 mentioned a lot of references in your report, about  
24 public hospital beds closing, that sort of thing,  
25 right?

1 A. Yes.

2 Q. We can agree, can't we, that the patient  
3 population at a public hospital is different from the  
4 patient population at a private hospital, true?

5 A. Yeah. There's some overlap. There are some  
6 patients who perhaps need short-term treatment and  
7 then subsequently need long-term treatment in a state  
8 institution. So they're not totally distinct, but the  
9 state facilities are focused more on the chronic,  
10 longer-stay patients.

11 Q. And the people who end up in state mental  
12 institutions, when they exist -- and they have existed  
13 in the past in Tennessee and there still are ones in  
14 Tennessee, right?

15 A. Yes.

16 Q. -- 99 percent of them are uninsured, right?

17 A. I don't know if I've seen that data, but  
18 that's been my experience, that generally they either  
19 have TennCare or they're uninsured.

20 Q. And many of them are homeless, right?

21 A. That's a particular segment of the population  
22 that end up at mental hospitals.

23 Q. And they're the sort of people that we see  
24 sometimes on our streets who are obviously mentally  
25 ill and living under a bridge or whatever, and they're

1 obviously ill, right?

2 A. Yes.

3 Q. And the problem that all these reports that  
4 you cite -- the major problem they've been talking  
5 about is the closure of these public beds, right?

6 A. Sure.

7 Q. And the problem they're raising is the closure  
8 of all of these public beds has led to all these  
9 people on the streets who probably need to be  
10 institutionalized, right?

11 A. Yeah. Or need to be in some sort of  
12 controlled environment if not in an institution, yes.

13 Q. And you know from looking at the SBH  
14 application that even if we accept the 5 percent  
15 indigent number that they've offered us, 95 percent of  
16 their patients are going to be people with some kind  
17 of reimbursement insurance, right?

18 A. Right. I mean, the TennCare population  
19 does go to the state hospital, but, sure, I mean,  
20 there's other categories where those -- for example,  
21 commercial insurance, those would be less likely to  
22 utilize a state facility.

23 Q. And you know, just while I'm on this topic,  
24 that some of the things you cited in your report, for  
25 example, this Treatment Advocacy Center publication,

1 that's a huge, several -- hundred-page document that  
2 you attached there that fortunately we didn't make an  
3 exhibit, but you mentioned it earlier today, right?

4 A. I did.

5 Q. And you would agree -- I'm just reading from  
6 the report itself. It says -- and this is at Page 8  
7 -- private psychiatric beds are not considered in this  
8 study, right?

9 A. The study specifically focused on the impact  
10 of closing public beds.

11 Q. And when they said throughout -- earlier today  
12 this number, 50 beds per 100,000, that came from here,  
13 right?

14 A. It did. There was a separate article that I  
15 also had in my exhibits that was the source of that  
16 particular number.

17 Q. And also by this group, though, right?

18 A. I think they published it, but it was a  
19 different author, I think.

20 Q. Okay. And the 50 beds per 100,000 is for  
21 public hospital beds, right?

22 A. That's true.

23 Q. And you would agree, wouldn't you, that if you  
24 adopted that standard in the United States today, it  
25 would require building more than 100,000 new public

1 hospital beds in our country, right?

2 A. I don't know the exact number. It would mean  
3 a significant increase in the number of -- I think I  
4 saw in one of these reports there's 45- to 50,000  
5 public hospital beds now. The overall average in the  
6 country is around 14 or 15 beds per 100,000. So,  
7 yeah, you would have to substantially increase the  
8 number.

9 Q. And, you know, that -- by the way, the people  
10 who came up with this recommendation, there were -- to  
11 be precise, it was 15 people, right?

12 A. Right. It was an expert panel.

13 Q. And the expert panel consisted of people who  
14 run public hospitals, right?

15 A. Right. And it might have been some academics  
16 thrown in there.

17 Q. You mentioned something about crime earlier  
18 today, and I guess -- I mean, you're not suggesting  
19 that SBH, building it, will help the crime rate,  
20 right?

21 A. It won't hurt it. It will -- it will result  
22 in another option for local law enforcement to  
23 utilize, and it may also result in people who live  
24 closer to that facility seeking inpatient treatment  
25 whereas they might be more reluctant to if they had to

1 travel farther to get it.

2 Q. You know, of course, that during this whole  
3 period of time you've been talking about, when all  
4 these beds have been closing in psychiatry in  
5 Tennessee -- you know that the violent crime rate has  
6 gone down, right?

7 A. I haven't studied it throughout the whole  
8 state. I don't know.

9 Q. And you've heard of the Markowitz study,  
10 right?

11 A. I have.

12 Q. And that's really the basis for the idea that  
13 there's a relationship between crime and psychiatry  
14 beds, right?

15 A. That was one of the documents. There was a  
16 couple of other studies that assessed the same thing.

17 Q. And Exhibit 322 --

18 MR. JACKSON: If I may, Your Honor.

19 BY MR. JACKSON:

20 Q. -- is a copy of the Markowitz study, right?

21 A. Yes.

22 Q. And the conclusion of the study was that --  
23 and if you look at the end of the abstract there on  
24 the very first page, "I find that public psychiatric  
25 hospital capacity has a statistically significant

1 negative effect on crime and arrest rates and that  
2 hospital capacity affects crime and arrest rates, in  
3 part, through its impact on homelessness." Do you see  
4 that?

5 A. I do.

6 Q. And then it says, "In addition, I find  
7 no crime-reducing effect of private and general  
8 psychiatric hospital capacity," right?

9 A. That's what it says.

10 Q. And that's because, as we were discussing, he  
11 evaluates and determines that the people in the public  
12 hospitals are not the same people that are in the  
13 private hospitals, right?

14 A. Yes.

15 MR. JACKSON: Your Honor, I'd tender 322.

16 THE COURT: Exhibit 322 be marked the  
17 article by Fred Markowitz from Illinois University,  
18 date of 2006. The article is entitled Psychiatric  
19 Hospital Capacity, Homelessness, and Crime and Arrest  
20 Rates.

21 (Marked Exhibit No. 322.)

22 BY MR. JACKSON:

23 Q. You were asked a number of questions,  
24 Mr. Sullivan, about deferral numbers, right?

25 A. Yes.

1 Q. And you would agree -- first of all, there was  
2 an improvement in the deferral pattern at Woodridge  
3 between 2013 and more recent years, right?

4 A. There was. I don't know that -- it looked  
5 like the deferrals were beginning to tick back up  
6 again in the most recent data, but there was an  
7 improvement from the six months in 2013 -- or seven  
8 months in 2013 we looked at, the first five months of  
9 2014, and then, I think, the second seven months of  
10 2014.

11 Q. And, in fairness, to figure out if the trend  
12 is going up, back or down again, you'd really want to  
13 see a little more data, wouldn't you, before you could  
14 draw any reliable conclusion?

15 A. Sure. I mean, I think we know that Woodridge  
16 has changed its policies and more patients are getting  
17 into beds now because their occupancy is going up, so  
18 you would expect the deferrals to go down. But now  
19 that they're at capacity, I would think that the  
20 deferrals potentially would be on the rise again.

21 Q. The highest -- well, they're at capacity --  
22 let me just ask you a couple of questions about that,  
23 Mr. Sullivan. Where Woodridge is right now, today, is  
24 basically where every single hospital operated by SBH  
25 is too, right, in terms of occupancy?

1 A. I don't know the answer to that.

2 Q. You know from sitting here in the courtroom,  
3 though, they told us that they run from 80 to  
4 85 percent, right?

5 A. That's true.

6 Q. And so that's at, you know, all these --  
7 they're in North Carolina, Nevada, Colorado, wherever  
8 they are, they're running at 85 percent capacity,  
9 right?

10 A. Yes.

11 Q. And the deferrals that were made that you  
12 talked about earlier, the most that were ever deferred  
13 at one six-month period would be about 242, it looks  
14 to me just from flipping through it. Does that sound  
15 about right?

16 A. For the adults?

17 Q. Yes, sir.

18 A. That sounds about right.

19 Q. And we don't know; some of those 242 people  
20 may have gone to one of the existing hospitals within  
21 the service area, right?

22 A. That's possible.

23 Q. And some of them may be reflected in these  
24 out-migration numbers, right?

25 A. Could be.

1 Q. So we can't really add those numbers to these  
2 numbers to come up with a total number. That wouldn't  
3 be reliable, right?

4 A. We don't know.

5 Q. But we can agree, can't we, that there's  
6 nowhere near enough people that have been deferred to  
7 fill a 72-bed hospital?

8 A. Yeah. That wouldn't be the sole source of  
9 patients.

10 Q. And you pointed out a few snapshots in time,  
11 if you will, when the hospital was really, really  
12 full, right?

13 A. That's -- that's been pretty much the first  
14 half of 2015.

15 Q. But you gave us a couple -- I remember there  
16 was a time in April, for example, when you showed us  
17 that it was, you know, at 95 percent capacity or  
18 something like that, right?

19 A. Sure.

20 Q. Do you know anything that goes on in the  
21 Tri-Cities in April every year?

22 A. That would result in psychiatric admissions?

23 Q. Yes, sir.

24 A. I don't.

25 Q. Well, do you know what NASCAR is?

1 A. I do.

2 Q. Do you know that there is a racetrack in  
3 Bristol?

4 A. I do. I've seen that race on TV.

5 Q. Do you know that about 160,000 people go to  
6 that every year?

7 A. I would accept your word on it.

8 Q. If you've ever tried to get a hotel room,  
9 as I have, in the Tri-Cities during April, you would  
10 understand this, I promise you. But I noticed that  
11 that week in April of this year when the occupancy hit  
12 these extremely high levels coincided with the Bristol  
13 races. You think there might be some connection  
14 there?

15 A. I wouldn't want to make a correlation to  
16 NASCAR fans.

17 Q. In fairness, without impugning NASCAR fans,  
18 and I really don't want to -- they're great people --  
19 when you double the population of a community, you're  
20 going to have some increased utilization of health  
21 care facilities, right?

22 A. Sure.

23 Q. Now, let's talk a little bit about impact,  
24 Mr. Sullivan. Right now there are about a thousand  
25 people -- a thousand cases of people who live in

1 Sullivan County but go down the road to Woodridge for  
2 their psychiatric care, right?

3 A. Yes.

4 Q. And they account for about a quarter of the  
5 admissions to Woodridge Psychiatric Hospital in  
6 Johnson City, right?

7 A. Woodridge's admissions have gone up. It may  
8 be a little less than 25 percent now. But based on  
9 the 2013 data, that's correct.

10 Q. And you would agree that if this hospital  
11 is built, some percentage of those people who are  
12 currently driving down the road from Sullivan County  
13 to Woodridge would go to the new hospital in Kingsport  
14 instead, right?

15 A. Sure. If they didn't, then this project  
16 wouldn't be accomplishing what it was setting out to  
17 accomplish.

18 Q. And, by the way, you would also agree that  
19 having a new hospital with all the bells and whistles  
20 that come with that is, itself, a driver of volume,  
21 right?

22 A. To a limited extent. I mean, the world has  
23 changed a bit in health care where -- insurance  
24 companies, physicians being employed by health care  
25 systems, there's less movement today than there would

1 have been ten years ago, but certainly some patients,  
2 if they have a choice, might choose to go to a newer  
3 hospital over an older hospital.

4 Q. Right. All other things being equal, if I can  
5 go to a brand-new hospital where I'm going to have to  
6 spend some time as opposed to a 30- or 40-year old  
7 hospital, I would probably choose the newer one,  
8 right?

9 A. Well, I think you would probably ask your  
10 psychiatrist first which hospital you should go to,  
11 but if he gave you the choice of going to either,  
12 then, yeah, you might choose the new, shiny one.

13 Q. So now we've got these folks from Sullivan  
14 County, some percentage of them is going to be  
15 diverted. The same is true with Hawkins. There's  
16 about 250 cases a year of people from Hawkins County  
17 that go to Woodridge currently. That's about 7  
18 percent of the volume, right?

19 A. Correct.

20 Q. And there are also some people from Virginia  
21 that come to Woodridge currently too, right?

22 A. They do.

23 Q. And to get to its projected volumes of  
24 approximately 2,000 cases a year, the new hospital is  
25 going to have to capture percentages of these Hawkins

1 patients, percentages of these Virginia patients, as  
2 well as percentages of these Sullivan County patients,  
3 right?

4 A. Sure, as part of the volume. And then the  
5 hope is that there will actually be a rise in the  
6 level of utilization as a result of the new hospital  
7 being constructed.

8 Q. That's right. You're hoping -- there's not  
9 going to be a rise because of population growth,  
10 right? That's not going to happen.

11 A. Right.

12 Q. But some percentage, you're hoping, will  
13 come out of the woodwork, if you will, to be treated  
14 for the first time or whatever, right?

15 A. Yes.

16 Q. And you've not done, though, and were not  
17 asked to do in this case, an impact analysis to  
18 estimate how many cases would be drawn from Woodridge  
19 from the patients who otherwise would have been seen  
20 at Woodridge, true?

21 A. True.

22 Q. And you certainly know how to do that kind of  
23 analysis, right?

24 A. Sure.

25 Q. And you've done it in other cases, right?

1 A. I have.

2 Q. You did it in the Covenant case, for example,  
3 right?

4 A. I did.

5 Q. And that was the case, I think, we tried here  
6 in this very courtroom and you were in that very  
7 witness stand and you were on behalf of somebody  
8 trying to get a CON, right?

9 A. That's true.

10 Q. And in that case, just as here, there was  
11 somebody opposing the CON, right?

12 A. Right. I believe that they had done an impact  
13 analysis, and I was responding to their impact  
14 analysis.

15 Q. But you actually did your own, though, didn't  
16 you?

17 A. I did.

18 Q. And you didn't do that here, right?

19 A. I didn't because I didn't have the benefit of  
20 seeing what I considered to be a reasonable impact  
21 analysis at the time I prepared my report.

22 Q. Well, you suggested earlier that there was  
23 some information -- like you didn't have access to our  
24 files or something like that. Do you remember saying  
25 that earlier?

1 A. Yes.

2 Q. You know, of course, we've been engaged in a  
3 discovery process in this case for quite some time,  
4 right?

5 A. I've got piles of documents, yes.

6 Q. And you-all have -- you managed to find some  
7 documents. Frankly, I'm not sure I've seen all the  
8 documents you exhibited today. You have detailed  
9 information on a daily basis about what was happening  
10 at Woodridge, right?

11 A. I do.

12 Q. And, of course, you've worked closely with  
13 these lawyers and told them other things to ask for,  
14 right?

15 A. I did.

16 Q. And you have had the opportunity to request  
17 through them whatever you might have needed to do a  
18 reliable impact analysis; isn't that true?

19 A. Well, I mean, what I was asking them to  
20 request were historical documents that existed. I  
21 wasn't asking them to ask Mountain States to produce  
22 reports that I could use against them. So I was  
23 asking for information that Mountain States already  
24 had in its possession that would be available for me  
25 to analyze their historical operations and

1 utilization.

2 Q. Well, it would have been -- we'll come back  
3 to that in a minute.

4 You were asked some questions about  
5 Exhibit 27, this email from Ms. McDevitt. Do you  
6 remember that?

7 A. I do.

8 Q. And you know, don't you, that, in fairness,  
9 what she was saying in this email was that this  
10 analysis showing that supposed \$50,000 impact, it  
11 didn't look right, did it? That's what she was trying  
12 to communicate in her email?

13 A. She said it wasn't what she was expecting.

14 Q. Right. So what she was telling the folks  
15 doing the number-crunching was something seems off  
16 about your work, right?

17 A. Well, I can't infer what she meant.

18 Q. Well, you seemed to put a lot of emphasis on  
19 it, so I just want to make sure you're being fair.  
20 And you would agree that what she said was you better  
21 take a second look at this and make sure you included  
22 all the costs, right, in essence?

23 A. That's not the way we read it. I read it that  
24 we needed to show a greater impact.

25 Q. You know that Dr. Collier has done an impact

1 analysis in this case, right?

2 A. I do.

3 Q. And you mentioned already today you've known  
4 Dr. Collier for quite a long time, right?

5 A. Yes.

6 Q. You-all started -- you started at the firm  
7 where she was working, right?

8 A. I did.

9 Q. You know her to be professional, right?

10 A. Yes.

11 Q. Well-qualified?

12 A. Yes.

13 Q. You know she used a standard methodology for  
14 calculating impact in this case?

15 A. I wouldn't say it's standard, but she used an  
16 approach that's been used somewhat in the past. There  
17 are some wrinkles that she introduced in this case  
18 that I hadn't seen done in a lot of other cases.

19 Q. You know what a proportionate draw assumption  
20 is, right?

21 A. I do.

22 Q. And that's what she did, right?

23 A. She did, but she did it on a payor-mix basis,  
24 which is a little bit different than the way these  
25 analyses are often approached.

1 Q. All right. You, yourself, though, have used  
2 the proportionate draw analysis, right?

3 A. I have.

4 Q. And, basically, when you do that, you assume  
5 that the new cases are going to be drawn, once we  
6 get past population, if that's -- that has to be  
7 calculated first, right, is the population going to  
8 grow?

9 A. Sure.

10 Q. If the population's not growing, then you  
11 assume that the cases the new facility is going to see  
12 are going to be taken in proportion to existing market  
13 shares of existing providers, right?

14 A. That is one set of the assumptions. In some  
15 cases, you vary from that based on other factors,  
16 such as if you know that a certain medical group is  
17 going to be practicing at a facility and they have a  
18 disproportionate or lesser proportionate share of the  
19 market; you would take that into consideration. But I  
20 would agree with you that this sort of proportionate  
21 impact analysis is one that's done frequently in the  
22 industry.

23 Q. And you've done it yourself?

24 A. I have.

25 Q. And so you also -- by the way, you talked a

1 lot in your impact analysis about these new cases you  
2 think are going to be coming out to be seen, right?

3 A. Right.

4 Q. You've never done any kind of calculation or  
5 estimate, have you, of how many of these 2,000 cases  
6 they're going to be seeing are going to be people that  
7 are new to the psychiatric care system, fair?

8 A. Well, I have once I saw Dr. Collier's report.

9 Q. Is that something you wrote down anywhere?

10 A. I have a spreadsheet, but I haven't -- I  
11 didn't write it down. I don't have it sitting in  
12 front of me.

13 Q. But that's not a spreadsheet you've shared  
14 with me?

15 A. It is not.

16 Q. You agree that to the extent SBH draws a  
17 disproportionate share of insured patients from  
18 Woodridge as compared to the state contract or  
19 uninsured patients, that's going to have a  
20 disproportionate impact, right?

21 A. If that, in fact, is what happens.

22 Q. And you agree that if SBH takes -- you know  
23 that Dr. Collier estimates that it will cost Woodridge  
24 about a thousand cases a year, right?

25 A. I saw that.

1 Q. If that happens -- and I know you disagree  
2 with that, but if that happens, that will be a  
3 material impact on Woodridge, true?

4 A. It would.

5 Q. And you know the financials of Woodridge,  
6 which you talked about earlier, while the facility is  
7 still profitable, it went -- the profitability went  
8 down by a substantial amount between last year and the  
9 most recent year, correct?

10 A. Yeah, which I found curious, because when  
11 you have a 10 percent increase in occupancy and your  
12 profitability goes down, that seems to fly in the face  
13 of Dr. Collier's assumption that when volume goes  
14 down, you lose significant dollars on the bottom line,  
15 but somehow when volume goes up, you don't increase  
16 the bottom line. There seems to be a fundamental  
17 anomaly there.

18 Q. Could part of that anomaly be the state cases  
19 that are undercompensated?

20 A. I didn't see that in the -- in the data that I  
21 looked at, that the general increase was only in the  
22 state patients. It appeared to be across all  
23 categories.

24 Q. Would you agree, though, one hypothesis that  
25 you'd want to explore would be whether or not maybe

1 the percentages got skewed as to state patients versus  
2 insured patients?

3 A. I'd want to know that, but, again, the state  
4 patients appear to have a positive contribution margin  
5 to the bottom line of Woodridge. So I would think  
6 that even with an increase -- I would have to look  
7 at the numbers. I just -- I can't speculate. But  
8 historically, based on the data we have, the state  
9 patients do provide a positive contribution margin to  
10 the operations.

11 Q. And you know, of course, that's -- when you  
12 say "a positive contribution margin," you're not  
13 including any allocation for administrative overhead  
14 or administrative centralized expenses, right?

15 A. I am not.

16 Q. And you do understand, like, for example,  
17 Mountain States does billing centrally, not at its  
18 individual facilities, but the bills are sent out for  
19 Mountain States? You know that, right?

20 A. Sure. But Mountain States has taken the  
21 position that those expenses are relatively fixed and  
22 shouldn't be included in the contribution margin.

23 Q. Well, that's not entirely -- there's both -- I  
24 don't want us to get off into fixed and indirect and  
25 direct at this late hour in the afternoon, but you

1 would agree that there's some direct fixed and  
2 indirect fixed costs in the analysis done by  
3 Dr. Collier, right?

4 A. There are both.

5 Q. And we'll let her speak to all that, but you  
6 haven't sat down and put pen to paper and tried to  
7 come up with your own analysis of that, right?

8 A. I have not.

9 Q. You have worked with Mr. West many times in  
10 the past, right?

11 A. I have.

12 Q. And you've worked on other psychiatric cases  
13 in the state of Tennessee, cases involving psychiatric  
14 beds in the state of Tennessee before, right?

15 A. I have.

16 Q. You mentioned one such case in Huntingdon,  
17 right?

18 A. Right.

19 Q. But you've also worked on a case over in  
20 Livingston too, right?

21 A. I did.

22 Q. And that case was one you worked on in 2007,  
23 right?

24 A. Yeah. I couldn't remember at my deposition  
25 when it was, but that sounds right.

1 Q. And Mr. West retained you in that case, right?

2 A. He did.

3 Q. And it's fair for us, isn't it, to look at the  
4 opinions you've expressed in other cases to make sure  
5 they're consistent with the opinions you're expressing  
6 here today?

7 A. Sure.

8 Q. And in that case you gave an expert opinion  
9 and you gave expert testimony, right?

10 A. I did.

11 Q. And it was about geropsych beds, right?

12 A. It was.

13 Q. And in that case Livingston Regional wanted to  
14 add some beds, right?

15 A. Right.

16 Q. And they proposed a service area that  
17 consisted of four counties, right?

18 A. They did.

19 Q. Overton, Cumberland, Putnam, and Fentress,  
20 that's what they claimed, right?

21 A. That sounds right. It's been a long time.

22 Q. And I've got the report. I'll be happy to  
23 share it with you shortly. But the first thing you  
24 did, you looked critically at their service area,  
25 right?

1 A. I did.

2 Q. Because you know that it's important for you  
3 to -- for anybody who's seeking a CON to use a  
4 reasonable service area, right?

5 A. I would agree with that.

6 Q. And that's actually in the regulations, right?

7 A. It is.

8 Q. And so in that case the first thing you did  
9 was looked at that, and you noted -- and let me pass  
10 up to you Exhibit 379.

11 MR. WEST: Your Honor, if I may, it's  
12 been about eight years since this report was done. It  
13 looks somewhat lengthy. I would ask that we -- that  
14 Mr. Sullivan be given time to examine it if he's going  
15 to be questioned in detail about it. So it may be  
16 appropriate to take a short break.

17 THE COURT: We can take a break. He may  
18 take him right to the page and it may not take long.

19 You don't necessarily have to read it  
20 during the break. You need to take your break too.

21 MR. JACKSON: I think, Your Honor, I can  
22 get through it just in a moment.

23 THE COURT: Okay.

24 BY MR. JACKSON:

25 Q. And I'll direct you to where we need to go.

1 If you need to take more time, then you --

2 THE COURT: Let me ask you this. How  
3 much longer do you have on cross?

4 MR. JACKSON: 15 minutes or so.

5 THE COURT: Do you have some redirect?

6 MR. WEST: A little bit, Your Honor,  
7 depending on where this goes.

8 THE COURT: Let's just take a short break  
9 and we'll come back and finish up. We've been going  
10 for about an hour and a half, I think.

11 (Recess observed.)

12 BY MR. JACKSON:

13 Q. Mr. Sullivan, during our break, did you have a  
14 chance to talk with SBH's counsel about Exhibit 379?

15 A. I did not.

16 Q. Okay. Good. I just saw you-all looked to be  
17 in rather serious conversation there, but I'm glad to  
18 hear it.

19 Page 3 of Exhibit 379 you start talking about  
20 the CON application service area as defined, right?

21 A. I do.

22 Q. And you pointed out, first of all, that this  
23 applicant had no specific data presented supporting  
24 the service area definition, right?

25 A. Right.

1 Q. And you expressed the opinion that because  
2 Clay, Pickett, and Jackson counties had accounted  
3 for a, quote, meaningful percentage of the historical  
4 discharges of this hospital -- that was the phrase you  
5 used, right?

6 A. Yes.

7 Q. -- that those counties should have been  
8 included in the service area, according to you, right?

9 A. Sure. This is an existing hospital that had a  
10 track record in terms of patient origin. So, you  
11 know, it was easy to define what their historical  
12 service area had been.

13 Q. Of course. So then you looked at that  
14 historical data and you came up with an alternate  
15 service area that you believed was reasonable and  
16 based on data, right?

17 A. Yes.

18 Q. And not only that, but if we look at Page 8 --  
19 and I've enlarged -- actually, we're not quite to the  
20 enlargement yet. If you look at Page 8 of your expert  
21 report, you looked not only at the health care  
22 facilities in the claimed service area, right?

23 A. True.

24 Q. And not only the health care facilities in  
25 your revised service area, right?

1 A. Right.

2 Q. But you actually looked at the other health  
3 care providers that were in close proximity to your  
4 redefined service area, right?

5 A. I did.

6 Q. And you looked specifically at all the  
7 contiguous counties where there were geropsych beds,  
8 and you even went a little beyond that, didn't you?

9 A. I did. I went, I think, one county over.

10 Q. And in determining whether or not there was  
11 any need in this geropsych case where you were working  
12 with Mr. West, you noted at Page 10, you said, first  
13 of all, "While it's correct there are no geropsych  
14 units in the proposed service area" -- that's what  
15 you said, right?

16 A. Yes.

17 Q. You said that service area is not reasonable,  
18 throughout their service area, right?

19 A. Right.

20 Q. For the reasons we discussed. You looked at  
21 the historical service area, that's your alternate  
22 service area, right?

23 A. Right. Because that's an operating hospital.  
24 It had actual patient origin data, unlike this case.

25 Q. Actual patient origin. And you looked at

1 those resources too, right?

2 A. I did.

3 Q. And then you also, though, in addition to  
4 that, you said here in your report that you submitted  
5 in this case -- other case, "Of equal importance,  
6 there are other existing geropsychiatric units located  
7 in counties that border the LRH service area that are  
8 also addressing the needs of this population," true?

9 A. Of the redefined service area, yes.

10 Q. That's right. And you looked at those  
11 resources, as well, in those adjacent counties, even  
12 to your expanded redefined service area, right?

13 A. I did.

14 Q. And that's because you believed, in your  
15 expert opinion, that it was appropriate to do that  
16 in assessing whether there was a need for these  
17 psychiatric beds in that particular community, true?

18 A. I did.

19 Q. You have no idea how SBH came up with the  
20 5 percent charity care in its application, right?

21 A. I was not involved in that, no.

22 Q. And not only were you not involved in it, but  
23 since you've become involved in the case, you've never  
24 seen an explanation about it, have you?

25 A. I have not.

1 Q. You've been paid more than \$50,000 to date?

2 A. Yes.

3 Q. Somewhere probably about 75 by now?

4 A. I don't know if it's quite that high, but it's  
5 more than 50.

6 Q. You talked earlier about Tennessee -- and I'm  
7 sorry to jump around. Now I'm getting to sort of my  
8 odds and ends. I apologize.

9 A. Okay.

10 Q. You talked about Tennessee having a D. Do you  
11 remember that?

12 A. I do.

13 Q. You agree that in that report that you  
14 referenced, most of the states had a D or an F, right?

15 A. Yeah. I think the average for the country was  
16 either a C or a D. I can't remember the exact.

17 Q. I'll represent to you -- if I represent to you  
18 there's 27 D's or F's -- I guess there's 50 states --  
19 can we agree the majority of the states have D's or  
20 F's?

21 A. Yes.

22 Q. And the reason Tennessee got a D wasn't  
23 because it lacked private psychiatric beds, right?

24 A. That wasn't the specific reason, no.

25 Q. And the criteria that -- there were various

1 criteria, none of which was you don't have enough  
2 private beds, right?

3 A. I don't recall that being specifically  
4 discussed.

5 Q. If this project's approved, we're not going to  
6 move from a D to a C?

7 A. It could be a stepping stone to improving the  
8 overall delivery of mental health services.

9 Q. In terms of the total number of psychiatric  
10 beds, if we look at the stuff that you have submitted,  
11 actually, Tennessee is about 28th out of 50 states,  
12 right?

13 A. In terms of?

14 Q. Beds per thousand.

15 A. Public or total?

16 Q. Total.

17 A. I think that's right.

18 Q. These flow sheets that you're looking  
19 at, you do understand, of course, as we mentioned  
20 in our case, that the Medicare standard is midnight  
21 census, right?

22 A. Yes.

23 Q. And it does have some practical impact,  
24 doesn't it, because you know that doctors round in the  
25 morning, typically, right?

1 A. They do.

2 Q. And if they have a patient who's in a hospital  
3 bed that needs to be discharged, they'll write an  
4 order when they round, right?

5 A. That's the typical pattern.

6 Q. And it will take usually some period of  
7 time -- it can be quite a long time if you're a  
8 patient waiting for the discharge, but there has to be  
9 paperwork processed, et cetera, to get the patient out  
10 the door?

11 A. Yeah. It's usually a few hours after the  
12 order is written that the patient's discharged.

13 Q. So the census that we take at 7:30 is going to  
14 include people that are currently -- if it's this kind  
15 of census, it's going to be people in a physical bed  
16 that are actually going to be gone, say, in the next  
17 couple of hours, right?

18 A. Sure. But if you want to move that back to  
19 midnight, that would be a reasonable approximation of  
20 what the midnight census was in those beds.

21 Q. Right. But my point is, when you've got these  
22 people on the waiting list that you referred to, we  
23 don't know, and you, at least, haven't done the  
24 analysis sufficient to figure out, how many of those  
25 people were waiting just for a few hours or what,

1 right?

2 A. I don't. That's the number that were waiting  
3 at that time of the morning.

4 Q. And some of those people, presumably, will be  
5 moved into beds shortly, right?

6 A. Yeah. I don't know what number.

7 Q. And you don't know, from your own personal  
8 knowledge, whether they're -- you know, these people  
9 who were waiting may have been getting some kind of  
10 care, right?

11 A. They may have been in a hospital emergency  
12 room getting care. They may have been waiting in an  
13 outpatient -- you know, in a partial hospitalization  
14 program. I don't know the answer to that.

15 Q. They may have been getting their medications,  
16 right?

17 A. Possible.

18 Q. Participating in therapy?

19 A. Possible.

20 Q. But all you know from these flow sheets is  
21 they're not occupying a physical bed at that point in  
22 the morning, right?

23 A. That's all I know.

24 Q. And you would assume, given that SBH runs  
25 at 85 percent occupancy, they have some times when

1 they're full too, right?

2 A. Sure. I'm sure they have times when they're  
3 full.

4 MR. JACKSON: I apologize, Your Honor.  
5 There's a lot of topics here. I just want to make  
6 sure I'm not forgetting something.

7 BY MR. JACKSON:

8 Q. Other than applying the 30-beds-per-100,000  
9 calculation to the service area that was created by  
10 SBH, you haven't done any other quantitative analysis  
11 in this case, true?

12 A. I think I went over my report earlier today  
13 where I was measuring the number of people, adults and  
14 children and adolescents, who had serious mental  
15 illnesses, and so I did estimate that population as  
16 sort of a second point of reference in terms of the  
17 size of the population, potentially, in need.

18 Q. And that was based on some national data,  
19 right?

20 A. Right. And the Tennessee data that I've seen  
21 was consistent with that national data.

22 Q. And other than that, other than coming up with  
23 those estimates -- and those estimates, you would  
24 agree those are kind of rough, right?

25 A. I wouldn't say rough. They measure the

1 prevalence of mental health disease in the community.  
2 That just shows the extent of the population who would  
3 potentially be candidates to receive inpatient  
4 treatment.

5 Q. Right. But, of course, you've not done any  
6 analysis to figure out what percentage of those people  
7 with illness actually rise to a level of needing  
8 inpatient care, right?

9 A. Right. I did not do that.

10 Q. And you would agree that inpatient care is  
11 kind of -- is the treatment of last resort, right, in  
12 psychiatric cases?

13 A. It is. In some cases it's a treatment of  
14 first resort if the patient is a danger to themselves  
15 or to the public.

16 Q. Right. But, in general, you don't want to  
17 prematurely or unnecessarily hospitalize people,  
18 right?

19 A. Sure. I mean, I think the goal is to keep  
20 people in the least restrictive setting.

21 Q. And you've not done any analysis  
22 quantitatively to figure out what percentage of  
23 mentally ill people in this particular part of  
24 Tennessee may actually need inpatient hospitalization,  
25 fair?

1 A. Other than what's presented in my report.

2 MR. JACKSON: That's all I have for now,  
3 Your Honor. Thank you.

4 THE COURT: Redirect.

5 MR. WEST: Thank you, Your Honor.

6 Mr. Jackson has given me the opportunity, after many  
7 years of practicing health care law, to ask a NASCAR  
8 question. It's truly a first. I don't mean to be  
9 flip, but this is a point that has been raised by our  
10 opponents.

11 REDIRECT EXAMINATION

12 BY MR. WEST:

13 Q. The NASCAR event that he asked you about you  
14 said you have seen on television or know about?

15 A. I do.

16 Q. And what county does it take place in?

17 A. Well, it's the Bristol Motor Speedway. I  
18 think it's actually in Virginia.

19 Q. And does it happen every year?

20 A. It does.

21 Q. So planning could be done for sudden surges of  
22 patients; is that correct?

23 A. That's correct. It seems unusual, but...

24 Q. Have you ever been asked a NASCAR question  
25 before?

1 A. No.

2 MR. WEST: All right. I would ask that  
3 the witness be given Exhibit 322.

4 BY MR. WEST:

5 Q. Do you still have it?

6 A. I don't have 322.

7 Q. It's the Markowitz article.

8 A. Okay.

9 (Document passed to witness.)

10 BY MR. WEST:

11 Q. Now, do you have Exhibit 322 in front of you,  
12 Mr. Sullivan?

13 A. I do.

14 Q. Would you look on Page 61?

15 A. Okay.

16 Q. And after the -- in the big paragraph -- there  
17 are only two paragraphs on the page, but in the lower  
18 paragraph, after the Fisher 2003 reference, would you  
19 read the next sentence?

20 MR. JACKSON: I'm sorry. What page are  
21 we on?

22 MR. WEST: 61.

23 THE WITNESS: "Together these findings  
24 suggest that community-based services from mental  
25 illness may not have that great an impact on the

1 number of persons arrested or in jail."

2 BY MR. WEST:

3 Q. All right. On the next page, Page 62, at  
4 the bottom of the last sentence, in the second full  
5 paragraph on the page, would you read that sentence,  
6 please, sir?

7 A. "In the absence of inpatient capacity"?

8 Q. Yes.

9 A. "More disturbing behavior becomes public,  
10 pressure increases on the police to clean up such  
11 behavior and opportunities for criminal victimization  
12 increase."

13 Q. All right. On the next page -- in the first  
14 full paragraph on the page, would you read the second  
15 sentence, please, sir, on Page 63?

16 A. Okay. "Further reductions in psychiatric  
17 hospital capacity, therefore, increase the burden on  
18 law enforcement and correction agencies."

19 Q. And will you read the last sentence in that  
20 paragraph, please.

21 A. "In light of these -- of the findings of  
22 the present study, these types of programs may be  
23 insufficient to take the place of public institutions  
24 focusing specifically on the inpatient care needs of  
25 persons with serious mental illness and substance

1 abuse disorders."

2 Q. And in that paragraph, can you find, just  
3 looking at it right now, when this author references  
4 "these types of programs," what he's talking about?

5 A. Community treatment alternatives, such as  
6 intensive care case management, jail diversion  
7 programs, and mental health courts for mentally ill  
8 persons.

9 MR. WEST: I believe that's all the  
10 redirect I have, Your Honor.

11 MR. JACKSON: Nothing further.

12 THE COURT: You can step down,  
13 Mr. Sullivan. Make sure you give that last exhibit  
14 back to --

15 THE WITNESS: I still have 379. I don't  
16 know. Was that marked?

17 THE COURT: It was not. You can give  
18 that back to Mr. Jackson.

19 (Witness was excused.)

20 MR. JACKSON: Your Honor, I did mean to  
21 tender 379. Did I tender that?

22 THE COURT: You did not.

23 MR. JACKSON: Your Honor, I'd tender  
24 Exhibit 379. I apologize.

25 THE COURT: Exhibit 379 will be marked

1 a report on Livingston Regional Hospital, Certificate  
2 of Need Application in Livingston, Overton County,  
3 Tennessee, prepared by Daniel Sullivan, February 2007.

4 (Marked Exhibit No. 379.)

5 THE COURT: All right. That will  
6 conclude our proof for today. Why don't we go off the  
7 record a minute and just talk about what we have for  
8 tomorrow.

9 (Discussion off the record.)

10 (Proceedings adjourned at 4:30 p.m. to be  
11 reconvened at 9:00 a.m. on July 29, 2015.)

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BEFORE THE TENNESSEE  
HEALTH SERVICES AND DEVELOPMENT AGENCY  
Nashville, Tennessee

IN THE MATTER OF: )  
 )  
SBH-KINGSPORT, LLC )  
 )  
 )  
Applicant, )  
 )  
vs. ) No. 25.00-126908J  
 )  
TENNESSEE HEALTH SERVICES )  
AND DEVELOPMENT AGENCY )  
 )  
 )  
Respondent, )  
 )  
and )  
 )  
MOUNTAIN STATES HEALTH )  
ALLIANCE, )  
 )  
Intervenor. ) Volume 3 of 5  
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TRANSCRIPT OF PROCEEDINGS

Taken before Administrative Law Judge Leonard Pogue

Commencing at 9:00 a.m.

July 29, 2015

**ORIGINAL**

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I N D E X

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P R O C E E D I N G S

THE COURT: Good morning. Mr. West, you can proceed to your next witness.

MR. WEST: Thank you, Your Honor. We call Michael Garone to the stand.

MICHAEL GARONE,  
was called as a witness, and after having been first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. WEST:

Q. Mr. Garone, could you state your name and address for the record?

A. Yes. First name is Michael, middle name Justin, last name Garone, G-A-R-O-N-E. Current address is 7600 Pleasant Colony Court in Las Vegas, Nevada, 89131.

Q. And at the time of your deposition you actually resided in Tennessee, did you not?

A. I did.

Q. Where was that?

A. 537 Township Cove, Collierville.

Q. And why the relocation to Las Vegas?

A. Several factors. My -- let me first state, I'm still in the same position that I was when I was living in Tennessee. My wife and young children

1 wanted to be back around family; so we made that  
2 decision to head back.

3 Q. You have extended family in the Las Vegas  
4 area?

5 A. We do, yeah. Both of our families are quite  
6 big, and they all still live back there; so although  
7 Memphis was a good experience for us, it was a  
8 challenge being away from family.

9 Q. And what is your job at Strategic Behavioral  
10 Health, if I may expedite things here?

11 A. Sure. I'm the Director of Development.

12 Q. And what does that job entail?

13 A. Basically I am in charge of looking at growth  
14 opportunities for the company, both organic or any  
15 acquisition-type opportunities or joint venture  
16 opportunities that might come.

17 Do you want me to go into great detail or  
18 just --

19 Q. I just want to get a general view what your  
20 duties are.

21 A. Sure. Well, basically what I would do is I  
22 would look at new markets, confirm kind of the  
23 feasibility for those markets, spend time in the  
24 markets looking at specific data sets, looking at  
25 conversations with stakeholders, looking at if it's a

1 CON market, doing the Certificate of Need application,  
2 reporting back to Jim what our findings are, putting  
3 plans together in terms of what strategy we want to go  
4 with.

5 Q. For the record, when you refer to "Jim," who  
6 do you mean?

7 A. I'm sorry. Jim Shaheen, the company's  
8 president.

9 Q. Is he in the courtroom today?

10 A. He is.

11 Q. All right. And how long have you held that  
12 position?

13 A. I started in May of 2013, I believe.

14 Q. So just a little over two years?

15 A. Yes, sir.

16 Q. And did you work for Strategic Behavioral  
17 Health prior to that?

18 A. I did.

19 Q. And what were your job duties there in that  
20 position?

21 A. The first position I held when Strategic  
22 acquired Montevista Hospital was community liaison,  
23 and about two or three months after they acquired the  
24 hospital, was moved into the Director of Marketing  
25 position.

1 Q. And where is that hospital you just referred  
2 to?

3 A. In Las Vegas.

4 Q. So you were living in Las Vegas at the time?

5 A. Yes, I was.

6 Q. What is your educational background?

7 A. I have my Business Administration degree from  
8 the University of Southern California.

9 Q. And in your working life, have you had any  
10 other jobs that were related to behavioral health or  
11 health care in any way?

12 A. I have. I think -- so my first job related to  
13 behavioral health was for a company called Las Vegas  
14 Recovery Center. My role there, my first role there,  
15 was kind of an administrative assistant to the  
16 administrator, was in that position for between a year  
17 and a half and two years. And then I was moved into  
18 more of a marketing position that was kind of the  
19 acting representative out in the community, building  
20 business and communicating with referral sources.  
21 Then I moved over into my position with Center For  
22 Change, which is an eating disorder program as their  
23 regional marketer.

24 Q. All right. You're aware that this proceeding  
25 that we're all at today has to do with the application

1 of SBH-Kingsport, LLC, for the establishment of a  
2 72-bed hospital in Kingsport, Tennessee?

3 A. Yes, I am.

4 Q. How did you come -- and you were involved in  
5 that CON application filing; is that correct?

6 A. Yes.

7 Q. Would you recount for the record how you came  
8 to be involved in it and what steps you took in your  
9 involvement?

10 A. Sure. So before I moved into the Director of  
11 Development position, there was a study done that  
12 looked at different markets. I can kind of go into  
13 detail about how that all came out. A statistician  
14 did a study that looked at any market that had over  
15 300,000 people and looked at different business  
16 metrics, such as the ability to staff the program, the  
17 cost to build, cost to operate, the need of the  
18 community in terms of the psychiatric beds per capita,  
19 several different metrics, weighted those metrics,  
20 came out with kind of a priority list of which markets  
21 we should be looking at; so we made the decision to  
22 look at the east Tennessee market, spent some time up  
23 there. And after consulting with Jim decided that we  
24 wanted to move forward with filing a Certificate of  
25 Need application.

1 Q. But the study that you just referenced, did  
2 you participate in that study?

3 A. I did not. I did, however, you know, the  
4 study was done at a higher level; so studied I want to  
5 say close to 100 markets. So what I did do was go in  
6 and kind of validate the information that was in that  
7 study to make sure that it was accurate and current in  
8 terms of the providers that were there, the population  
9 numbers, and those type of things.

10 Q. So who made the decision -- who ultimately  
11 made the decision to proceed in the application for  
12 CON up in east Tennessee?

13 A. Jim Shaheen.

14 Q. The CON at issue in this case?

15 A. Yes.

16 Q. So the decision was made by Mr. Shaheen. What  
17 were your next steps in carrying out his decision?

18 A. Get my head wrapped around the application  
19 process, engage counsel that could help us navigate  
20 that process. We identified a Realtor that could help  
21 us identify a site for the hospital, got into kind of  
22 what I'll call the kind of stakeholder due diligence  
23 in terms of meeting, identifying stakeholders, meeting  
24 with them either by phone or in person to understand  
25 what their perception was of the need within their

1 community as it relates to mental health. Those were  
2 kind of the next steps.

3 Q. When you use the term stakeholder, what do you  
4 mean by that?

5 A. In a broad sense, I believe everyone within a  
6 community has a vested interest in the behavioral  
7 health needs of a community, but specifically when I'm  
8 talking about stakeholders, I'm talking about  
9 individuals that would be with, let's say, a school  
10 district or law enforcement or mental health  
11 professional that deal with the issue of mental  
12 illness on an ongoing and sometimes daily basis, both  
13 from trying to treat and/or trying to help somebody  
14 get engaged with care that's appropriate for them; so  
15 we look at kind of a large cross segment of the  
16 population to see who those people might be.

17 Q. Do you follow this process in other markets as  
18 well?

19 A. I do.

20 Q. And how did this project come to be located in  
21 Kingsport?

22 A. So the eastern Tennessee market that was  
23 looked at during the -- I'll refer to it as the intern  
24 project, if that's okay with the Court, the intern  
25 project that I referenced earlier. So what I did was

1 I went into the community, met with some individuals.  
2 And the first place we went in was in Johnson City.  
3 Spent some time with them, understood relatively  
4 quickly that there was a provider in Johnson City that  
5 could accommodate the needs of that county. And so  
6 the next move was to talk with people up north in  
7 Kingsport, which did not have a facility of any great  
8 size, and it made better sense for us to be up there.

9 Q. And the facility you mentioned in that answer,  
10 you're speaking of psychiatric inpatient hospital  
11 facilities?

12 A. Yes, I am.

13 Q. How did you pick out the individual actual  
14 physical proposed location for the SBH-Kingsport site?

15 A. It was through the help of our Realtor.

16 Basically what we describe is what we look for in a  
17 site in terms of size, in terms of proximity to the  
18 interstate knowing that we're kind of a regional  
19 destination. We look at proximity to med-surg in the  
20 event that somebody escalates beyond our scope of care  
21 on the medical side of things and the -- you know, we  
22 also kind of look at the conditions of the site, if  
23 there is a lot that needs to be done in terms of site  
24 work, if there's harsh topography, you know; so we  
25 have our ideal things that we look for.

1           There were two sites that came back as -- that  
2           looked relatively good for us. We decided on one  
3           because it was smaller, we didn't need the extra  
4           acreage. So short answer to your question, which I  
5           know it wasn't a short answer, was through the help of  
6           our Realtor.

7           Q.           And the sites that you were referring to that  
8           you looked at, were they both in Kingsport?

9           A.           They were.

10          Q.           And you mentioned proximity to  
11          medical-surgical hospital facilities as one aspect of  
12          what you looked at?

13          A.           Yeah.

14          Q.           What is the distance between your proposed  
15          site for this SBH-Kingsport facility and the nearest  
16          acute care hospital? You can estimate?

17          A.           Approximately a half a mile.

18          Q.           All right.

19          A.           Maybe a mile at the most.

20          Q.           And what facility is that?

21          A.           Indian Path.

22          Q.           All right. Is it true also that Wellmont has  
23          facilities, inpatient hospital facilities, in  
24          Kingsport?

25          A.           Yes.

1 Q. So I'm taking a quick view of this. I'll come  
2 back to the individual more specific questions.

3 So after this process you described about when  
4 was the CON application filed, the exact we can  
5 determine from the document, I wanted to ask you what  
6 month it was filed in?

7 A. I believe it was filed in December.

8 Q. And do you remember when it was deemed  
9 complete by the HSDA staff?

10 A. I don't know the exact date. It took several  
11 months of back and forth.

12 Q. But it would be in the application presumably?

13 A. Absolutely.

14 Q. In your experience in Tennessee, now having  
15 gone through the CON application, once you filed, is  
16 that the end of the process with the staff? just this  
17 first initial application?

18 A. I guess that could be the case. In our case  
19 it was not. There was a series of supplemental  
20 requests for additional information or clarifying  
21 information.

22 MR. WEST: All right. And if I may  
23 approach the witness, Your Honor.

24 THE COURT: You may.

25 MR. WEST: I've already spoken with the

1 court reporter about pulling out these exhibits. If I  
2 may speak to Mr. Jackson momentarily.

3 BY MR. WEST:

4 Q. Let me show you a document marked Exhibit 9,  
5 and ask if you can identify it.

6 A. This looks to be the application, Certificate  
7 of Need application.

8 Q. And if you'll leaf through it quickly, are the  
9 supplemental responses that you referenced, are they  
10 in place?

11 MR. WEST: If I may approach, again, Your  
12 Honor.

13 THE COURT: You may.

14 THE WITNESS: They're probably at the  
15 back here. Yeah, they are, they're included in this.

16 BY MR. WEST:

17 Q. In the process that the HSDA follows, you're  
18 what is designated as the contact person; is that  
19 correct?

20 A. That's correct.

21 Q. And did you execute -- sign for this  
22 application and supplementals?

23 A. Yes, I did.

24 Q. All right. You can set that up on the ledge  
25 there. I wanted to ask you, if I may approach again,

1 about another document. Can you identify that? I  
2 think it's Number 14; is that right?

3 A. Yes.

4 Q. Exhibit 14, can you identify that document,  
5 Mr. Garone?

6 A. Yes. This looks to be a document I refer to  
7 as a stakeholder tracker.

8 Q. Is that one of your documents? Do you keep  
9 that up?

10 A. Yeah, I generated this document.

11 Q. And can you describe your use of the document  
12 and what it contains?

13 A. Sure. Well, on the -- it's broken down in  
14 columns. On the first column on the left it kind of  
15 classifies the segment that the stakeholder falls  
16 within, whether it's the med-surg community, the  
17 mental health center, social services, law  
18 enforcement. And then it has the agency name, a  
19 contact person, the title of the contact person, the  
20 date of the meeting if there was a face-to-face, and  
21 then just some notes to help me remember what we spoke  
22 about, and if there was any follow-up that was  
23 necessary.

24 Q. Do you use a similar type of documentary  
25 approach in all of the other projects you work on?

1 A. I do. It's very similar, yeah. It just helps  
2 -- there are so many different people that I'm meeting  
3 with. It's my way of kind of keeping it all in one  
4 spot.

5 Q. Let me step back for a second in terms of what  
6 you've been talking about and ask you, for this year  
7 of 2015, are there other projects that you're involved  
8 in in a similar fashion for Strategic?

9 A. There are.

10 Q. In what states are they located?

11 A. Let's see. Are you asking from the time I  
12 started this project till now?

13 Q. No, just this year.

14 A. Just this year, Johnstown, Colorado;  
15 Harlingen, Texas; Green Bay, Wisconsin and two  
16 different markets in the state of Iowa.

17 Q. And in your work in those states, you would  
18 utilize a similar tracker document?

19 A. Yes.

20 Q. So if the Court or the lawyers and the parties  
21 wanted to identify dates and times of meetings or  
22 contacts with what you call stakeholders, this  
23 document would provide them?

24 A. For the most part, yes. I don't want to say  
25 that it's 100 percent current. I think there's

1 obviously opportunity there for me to not have a  
2 detailed note. Maybe I met with somebody twice. I  
3 might only have the first meeting date on there or  
4 something like that. But for the most part, this  
5 would be the document that I would reference to get a  
6 snapshot of who I met with and when.

7 Q. So looking at that document, up until the time  
8 the CON application was deemed completed, I believe it  
9 was in the end of January, what are the types of  
10 contacts you had had during that time period? Can you  
11 tell from the tracker?

12 A. The types of contacts?

13 Q. Well, let me just make it easier. The dates  
14 of contacts, what are the months you met with people  
15 before January 31st?

16 A. Well, there were meetings from October through  
17 January, each of the months. Looks like there's  
18 probably at least one meeting that occurred, several  
19 of which happened after -- well, the interaction with  
20 stakeholders happened all the way up to the time when  
21 we met with the HSDA in June.

22 Q. June of 2014?

23 A. Correct.

24 Q. When they voted on the CON?

25 A. That's right.

1 Q. Was Mr. Shaheen involved in the CON  
2 application process prior to its being deemed  
3 complete?

4 A. Yes.

5 Q. And so did you -- how did you all coordinate  
6 work in this matter? or to what extent?

7 A. Sure. I think Mr. West was also involved in  
8 that process. We kind of went through the  
9 application, and there were certain sections that he  
10 had better knowledge of than I would; so he assisted  
11 with that. For the most part, I was the one who kind  
12 of collected and entered information, but I wouldn't  
13 necessarily say I authored all of it. I was through a  
14 collaboration; so there were some areas that were, you  
15 know, kind of beyond my scope of knowledge that he had  
16 better knowledge about, he would assist in that way.

17 Q. All right. So Mr. Shaheen himself by this  
18 point in the company's career -- let me back up. In  
19 January of 2014, do you know roughly how many  
20 psychiatric hospitals SBH was operating?

21 A. January of '14 -- seven. The eighth came on  
22 in April.

23 Q. Of 2014?

24 A. Of 2014.

25 Q. And those hospitals that were developed or

1 coming online or whether by acquisition or  
2 construction, at that point in your career, had you  
3 been involved with those projects?

4 A. Well, not all of them. I had some involvement  
5 with the Johnstown project, which was a new build. It  
6 is not currently operational. Oh, I'm sorry. Your  
7 question was of the seven that are currently  
8 operational?

9 Q. Yeah.

10 A. Yeah, I did not have -- I wasn't on board when  
11 they came on line.

12 Q. You spoke a moment ago of the HSDA meeting.

13 A. Yeah.

14 Q. That was on June 25, 2014?

15 A. That sounds right.

16 Q. Did you appear at the meeting?

17 A. I did.

18 Q. Did you speak on behalf of this application?

19 A. I did.

20 Q. Who else spoke on behalf of the application?

21 A. Mr. West, Mr. Shaheen, myself and several  
22 individuals that were in support on our side. Of  
23 course, I think it's fair to say that there was  
24 opposition there as well.

25 Q. All right. And do you know how many people,

1 other than people affiliated with Strategic, such as  
2 the counsel and Mr. Shaheen spoke, do you recall how  
3 many people spoke in support of it?

4 A. I don't know the exact number, but I would say  
5 approximately eight to ten people.

6 Q. But that can be ascertained, for example, from  
7 the transcript of the meeting?

8 A. Absolutely, yes.

9 Q. And in the course of preparing this  
10 application or in the course of preparing and then  
11 presenting this application to the HSDA, were there  
12 letters of support that were received by the HSDA, to  
13 your knowledge?

14 A. Yes, sir.

15 Q. And were there letters of opposition?

16 A. Yes, there were.

17 Q. Do you have any idea or can you speak as to  
18 how many letters of support were received?

19 A. Approximately 25 to 28.

20 Q. All right. And were they -- who did they come  
21 from? What types of people?

22 A. They came from stake -- well, I keep using the  
23 word stakeholders but --

24 Q. You can use that expression if it's your  
25 answer.

1 A. Yeah, they came from stakeholders within the  
2 community that we intend to serve, representations  
3 from provider groups, from state departments, from  
4 city municipalities, from judicial, from law  
5 enforcement, counties, social services, school  
6 districts, the people that have a strong vested  
7 interest because they deal with it every day.

8 Q. And let me step back from the meeting for a  
9 second and ask you, what is the service area proposed  
10 in the CON application?

11 A. It's the five counties that include Sullivan  
12 and Hawkins within Tennessee, Lee, Scott, and Wise  
13 within Virginia.

14 Q. You specified as the contact person, you  
15 specified in the application that was the proposed  
16 service area; is that correct?

17 A. That's correct.

18 Q. And how did that service area come to be  
19 designated in the application?

20 A. Sure. I think one of the areas that we look  
21 at, of course, is need for psychiatric beds. We kind  
22 of rely heavily on the 30 beds per 100,000 ratio  
23 that's adopted within the State Health Plan. We look  
24 at the ability to staff our programs. We look at  
25 concentration of population. We look at whether or

1 not there is existing providers. The first trip I  
2 made up I mentioned was to Washington County in  
3 Johnson City. It was evident that there was a  
4 provider there that could attempt to meet the needs of  
5 that county; whereas, in the five counties that we  
6 designated as our service area, there was only one  
7 provider that operated a 12-bed unit, adult unit, in  
8 Bristol, Tennessee.

9 Q. You were at the hearing -- you were at the  
10 hearing at the HSDA on June 25, 2014?

11 A. Yes.

12 Q. What was the vote at the hearing?

13 A. The vote was a 4-4 tie.

14 Q. Now, in the application -- in this area of  
15 healthcare we use, you and other people, including  
16 lawyers, use an expression called "average length of  
17 stay."

18 A. Uh-huh.

19 Q. So can you describe your understanding of what  
20 that means?

21 A. Yeah. An average length of stay would be  
22 basically over any given period of time, whether it's  
23 a month or a year, you take the number of patient days  
24 divided by the number of days within that period of  
25 time and that's your average length of stay. So I

1 guess another way to look at it is how long each  
2 patient is within your care from time of admission to  
3 time of discharge.

4 Q. And the expectation would be that a typical or  
5 average patient would have that length of stay in your  
6 facility?

7 A. Right.

8 Q. In the application itself, what was the  
9 average length of stay projected?

10 A. It was projected at 12 days.

11 Q. What steps -- is that still your projection?

12 A. No, the projection now and that was presented  
13 during the discovery responses to Mountain States was  
14 9.2 days.

15 Q. So the appeal process was already ongoing then  
16 when that was presented?

17 A. That's correct.

18 Q. And is that still your current expectation of  
19 average length of stay at this facility?

20 A. It is.

21 Q. All right. So instead of the 12 days in the  
22 application, it's 9.2 days?

23 A. 9.2 days.

24 Q. All right. And how did you determine the 9.2  
25 day figure?

1 A. Well, we looked at the -- well, I guess the  
2 first thing to mention is that the existing operations  
3 that we have throughout the country, we looked at the  
4 average length of stay for acute inpatient services  
5 within those hospitals, took into consideration kind  
6 of the bed complement or bed distribution within the  
7 existing providers and within our proposed bed  
8 complement. We also looked at some of the joint  
9 annual reports for providers within the area and came  
10 to that 9.2 days.

11 MR. WEST: May I approach the witness  
12 again, Your Honor?

13 THE COURT: You may.

14 BY MR. WEST:

15 Q. Let me show you the document that has been  
16 marked as Exhibit 11, and ask you if you can identify  
17 that.

18 A. This looks like this is the pro forma that was  
19 done for the project for its build year, year one of  
20 operation and year two of operation.

21 Q. Could you read the exhibit number at the  
22 bottom there?

23 A. Exhibit 11.

24 Q. In Exhibit 11, what is the date shown at the  
25 upper left corner of the first page?

1 A. 13th of October 2014.

2 Q. And what's the title of it that you can see  
3 there next to the date?

4 A. It says "Kingsport," and then it's got a title  
5 of "Build Year"; so we know which timeframe we're  
6 talking about.

7 Q. All right. And if you look down at the bottom  
8 of that page, what is indicated as to the length of  
9 stay?

10 A. The length of stay is populated at 12.

11 Q. So at that point in time in your analysis  
12 then, you were contemplating a 12-day length of stay  
13 in terms of generating that spreadsheet?

14 A. Well, I would say it a different way. I would  
15 say that at this point in time that was the number  
16 that was in that cell that generated the rest of the  
17 document. Not much thought was given to length of  
18 stay in this pro forma.

19 Q. Why is that?

20 A. Well, the pro formas that we use are Excel  
21 spreadsheets that have certain cells that are  
22 pre-populated and certain cells that are formula  
23 driven. This particular pro forma is one that you  
24 plug in the number of admissions and it calculates  
25 your patient days based on a set number that's in the

1 average length of stay column. So we build these pro  
2 formas based on the average daily census that we  
3 believe we can ascertain and that we use during our  
4 ramp up period; so when we go in here we enter the  
5 number of admissions to generate the average daily  
6 census, and that's where the focus was.

7 Q. All right. And given the changes in the  
8 average length of stay that you have indicated, what  
9 is your expectation as to its impact on the number of  
10 days, for example?

11 A. The number of patient days, as well as the  
12 average daily census, will not change. What we will  
13 do is we will allow for more admissions to offset the  
14 decrease in length of stay to maintain the same  
15 patient days and the same averages.

16 Q. What is your expectation as to whether there  
17 is a need or demand for those days?

18 A. There's absolutely a need for those days. The  
19 reason why is when we ramp up our programs, we don't  
20 ramp them up based on the demand. We believe very  
21 strongly that the demand is there day one to operate  
22 at close to capacity, or else we wouldn't be doing the  
23 project in the first place. The reason why you see  
24 this gradual ramp up in average daily census, gradual  
25 ramp up in admissions, it's not because the demand

1 isn't there day one, it's because internally it's the  
2 right way to open an inpatient psychiatric hospital is  
3 to manage and bring it out of the ground, make sure  
4 people are staffed or trained, make sure that there is  
5 reasonable expectations from referral sources, make  
6 sure that we're doing it in the safest and most  
7 therapeutically beneficial way possible operationally;  
8 so part of our challenge in the first few years of  
9 operation are keeping the pace of admissions down,  
10 even though the demand is there.

11 Q. All right. In the application, how many years  
12 of projected operational data does the HSDA require  
13 you to specify?

14 A. Two years of operational data.

15 Q. All right. And that's in charts in the  
16 application?

17 A. Yes.

18 MR. WEST: Your Honor, if I may take just  
19 a moment, I just want to confer with Mr. Shaheen.

20 BY MR. WEST:

21 Q. Mr. Garone, in your stakeholder tracker that  
22 you've described and in your stakeholder comments,  
23 what use, if any, do you make of their feedback from  
24 your conversations or contacts with them?

25 A. Sure. Well, I think there's certainly

1 data-driven analysis, but there's also what's not set  
2 in the numbers. So when we meet with communities,  
3 we're basically trying to understand from people who  
4 live it every day what their experiences are like.  
5 And so when they voice their opinions that heavily  
6 weights the way that we look at things. You know, we  
7 believe strongly that everyone deserves access to  
8 quality mental health services, and when you've got  
9 stakeholders that are frustrated and you hear personal  
10 accounts of people not able to access care, it just  
11 confirms what the statistical analysis for beds per  
12 100,000 states; so we take that in high regard when  
13 we're making decisions.

14 Q. When you supplement, when you do a  
15 supplemental response to the HSDA, as you have done in  
16 those documents and in preparing the CON application,  
17 did you utilize the feedback from the stakeholders  
18 that you've described?

19 A. I did.

20 Q. And so that includes both the application and  
21 the supplements?

22 A. Yes.

23 MR. WEST: Your Honor, I believe that's  
24 all the questions I have for Mr. Garone.

25 CROSS-EXAMINATION

1 BY MR. JACKSON:

2 Q. Good morning, Mr. Garone. How are you today?

3 A. I'm well. Thank you.

4 Q. Your educational background is in marketing;  
5 is that right?

6 A. Business administration, yes, and my senior  
7 year emphasis was in marketing.

8 Q. You didn't have any formal training in health  
9 planning or anything of that nature; right?

10 A. I did not.

11 Q. After you graduated from college -- I think  
12 you graduated in 2001; is that right?

13 A. That's correct.

14 Q. After that you worked in the casino industry  
15 for a few years; right?

16 A. That's right.

17 Q. And you were marketing slot machines?

18 A. Yes, gaming.

19 Q. Right. And then you went into the healthcare  
20 business after that; right?

21 A. Yes.

22 Q. And you were working for a couple of different  
23 for-profit hospitals out in Las Vegas; right?

24 A. I wouldn't call them hospitals. One of them  
25 was a treatment center that did not have the hospital

1 designation; the other was an out-patient facility.

2 Q. And what you were doing for both of those  
3 facilities was marketing; right?

4 A. The first job was more of helping the  
5 administrator, and then the latter of the two  
6 positions were both marketing related.

7 Q. Ultimately, one of the places you were working  
8 got bought by SBH, and that's how you came into their  
9 employ; right?

10 A. That's correct.

11 Q. And then you were promoted and moved to the  
12 headquarters, I think you told us in May of 2013. You  
13 actually didn't arrive at headquarters until later  
14 that summer; is that right?

15 A. Yeah. I believe I was offered the position  
16 and started the position in May and then I physically  
17 relocated in August.

18 Q. And this project when you got to Memphis in  
19 August, this was kind of your first big assignment at  
20 SBH; wasn't it?

21 A. The first one that I was involved with from  
22 the start of the project.

23 Q. And this was the first time you had been  
24 involved in a Tennessee CON project; right?

25 A. Yes.

1 Q. And you had never actually been to Kingsport  
2 before you started working on the project; right?

3 A. Correct.

4 Q. And you went up there, I think you told us in  
5 October; right?

6 A. Yeah. October -- I think the October meeting  
7 was -- the first one was to Johnson City.

8 Q. Johnson City, okay. Then you went up again in  
9 November?

10 A. I believe so.

11 Q. And of course the application was filed in  
12 December, and you've been up there since then a few  
13 times; right?

14 A. Yes, sir.

15 Q. How many nights do you think you've spent in  
16 the Tri-Cities?

17 A. I think, this is an approximation: I think  
18 I've probably been up there six times and each time  
19 maybe two nights apiece; so a dozen times maybe.

20 Q. Okay. Now the statistical analysis, the  
21 intern project you were talking about, you didn't have  
22 anything to do with that, that was done before your  
23 time at headquarters; right?

24 A. Right.

25 Q. And you don't know exactly how the Tri-Cities

1 jumped up to the top of that list?

2 A. To the top of the list?

3 Q. Yes, sir.

4 A. I'm not sure what you mean. It never moved on  
5 the list.

6 Q. Sure. You'll agree with me that the  
7 Tri-Cities area on the intern's projects analysis was  
8 never number one in terms of need; right?

9 A. It was never number one in terms of need;  
10 correct.

11 Q. And it was not really number one in terms of  
12 anything; right?

13 A. Number one, no. It wasn't number one in terms  
14 of anything.

15 Q. And as far as knowing or ever seeing any  
16 document or written explanation of why the Tri-Cities  
17 was selected out of those other cities, you haven't  
18 seen such an analysis; right?

19 A. I have not seen or know of any analysis that  
20 was written, but I've been involved with conversations  
21 of why it moved up.

22 Q. Sure. You know that the real driving factor  
23 was the staffing. Staffing is good up there, right?

24 A. That's right.

25 Q. There's people you can hire and the wage rates

1 are lower than average in the country; right?

2 A. Yeah. I would say the staffing matrix was  
3 high, and that was the major contributor of why it got  
4 moved up on our priority list.

5 Q. And when you first started looking -- when you  
6 first went up there, as you told us, you went to  
7 Johnson City, and that was where you were first  
8 thinking about putting the hospital; right?

9 A. Well, that was the first area that we started  
10 collecting information, and I reached out to several  
11 different people up there. We hadn't really looked at  
12 sites yet, but that was a consideration.

13 Q. You actually applied for incentives from the  
14 Washington County Development Authority, right?

15 A. Yeah, I filled out their application.

16 Q. And sometime between when you filled out that  
17 application, which I'll represent to you was on  
18 October 7th of 2013.

19 A. Okay.

20 Q. Sometime between then and when you filed the  
21 application you made the decision to move the project  
22 or put it in Kingsport; correct?

23 A. Correct.

24 Q. And you don't have any -- there's no written  
25 document that you all prepared anywhere that analyzes

1 Kingsport versus Johnson City, true?

2 A. Analyzes it in terms of what?

3 Q. Well, in terms of anything. In terms of need,  
4 for example?

5 A. Say the question one more time.

6 Q. Sure. You all don't have a written document  
7 anywhere in your company's files where you've laid out  
8 the case for need in Johnson City versus the case for  
9 need in Kingsport; true?

10 A. True.

11 Q. You did know that --

12 MR. JACKSON: May I approach, Your Honor?

13 THE COURT: You may.

14 BY MR. JACKSON:

15 Q. I'll hand you a document we've marked as  
16 Exhibit 325, Mr. Garone. This is a series of emails.  
17 Let me ask you to flip back to the last email on  
18 page 4 of Exhibit 325. You were sending this in an  
19 email that you wrote dated October 31st, 2013; is that  
20 right?

21 A. October 31st, 2013; correct.

22 Q. And you were writing to Chris Reid and Jill  
23 Sullivan and you copied Mr. Shaheen, your boss; right?

24 A. Yes.

25 Q. And who are Chris Reid and Jill Sullivan?

1 A. Chris Reid is the principal at Thomas  
2 Construction, which is the company that we used to  
3 build our facilities. Jill Sullivan, I don't know her  
4 title, but she basically is his administrative  
5 assistant.

6 Q. You were writing to them, as you say in your  
7 first sentence of your email, to ask for their  
8 assistance in the Tennessee CON application for  
9 Kingsport; right?

10 A. Yes.

11 Q. And in your email you told them, quote, "You  
12 will notice that we have switched the physical  
13 location of the project from Johnson City to Kingsport  
14 in an attempt to avoid Mountain States Health Alliance  
15 from contesting our application," closed quote.  
16 That's what you wrote to them, isn't it, Mr. Garone?

17 A. Yes, it is.

18 Q. And then you told them that you were working  
19 under a very tight timeline; correct?

20 A. Yes.

21 Q. And at that time your attorney, Mr. West I  
22 presume, was recommending that you get your  
23 application on file by November 8th, which was only  
24 nine days from the date of this email; right?

25 A. Correct.

1 Q. And so you said you were scrambling to get  
2 everything put together in time; right?

3 A. Yes.

4 Q. Of course, you ended up actually taking -- you  
5 waited another month, another cycle, because you  
6 couldn't get it all together in that period; right?

7 A. Yes.

8 Q. And you point out -- you have below that, you  
9 say this project will be the 72-bed facility. Do you  
10 see that?

11 A. I see that.

12 Q. And when you say the 72-bed facility, you all  
13 have a couple of different plans on the shelf, so to  
14 speak, of different-sized hospitals; right?

15 A. Yes.

16 Q. And one of them is a 72-bed model, right?

17 A. Correct.

18 Q. And that's the one you told the architects, or  
19 whoever these folks are, the construction people,  
20 that's the one you told them you were going to use in  
21 this project; right?

22 A. That's right.

23 MR. JACKSON: If I may approach, Your  
24 Honor. Your Honor, I would move Exhibit 325 into  
25 evidence, please.

1 THE COURT: Exhibit 325 will be marked.  
2 It's a series of emails involving Mr. Garone,  
3 Mr. West, Laura Miller, Chris Reid, and Jill Sullivan,  
4 and the timeframe is December 2013, November 2013 and  
5 October 2013.

6 (Marked Exhibit No. 325.)

7 MR. JACKSON: May I proceed, Your Honor?

8 THE COURT: Yes.

9 BY MR. JACKSON:

10 Q. Mr. Garone, I'll hand you what I've marked as  
11 Exhibit 378. This is an email you sent to Lucretia  
12 Sanders; is that right?

13 A. That's correct.

14 Q. Dated January 23rd, 2014?

15 A. Correct.

16 Q. That's shortly after the application had been  
17 filed; right? or about the time it was deemed  
18 complete I believe; right?

19 A. Yeah, I think it was before it was deemed  
20 complete. Is that what you said?

21 Q. Yes. Well, it was after -- I asked you two  
22 questions. Let me back up. It was after it was  
23 actually filed; correct?

24 A. After it was filed.

25 Q. But before it was deemed complete?

1 A. Certainly. Yes, sir.

2 Q. And one of the things you're doing -- well,  
3 let's just take a look at this email. First of all,  
4 you are writing to Ms. Sanders, she works at the  
5 Department of Children's Health, I believe?

6 A. Yeah, the Department of -- DFS, so Division of  
7 Family Services or Department of Children's Health.

8 Q. And one of the things you're soliciting her to  
9 do is to write a letter of support; right?

10 A. Yes.

11 Q. And you actually reached out to a number of  
12 people in the community and actually asked them to  
13 write those letters of support that you mentioned in  
14 your testimony earlier; right?

15 A. I did.

16 Q. And you said you sent some sample letters out  
17 for them to review; right?

18 A. Yes.

19 Q. And you suggested -- for example, you told  
20 Ms. Sanders here in the end of this second paragraph  
21 of your email, you said, "Specifically what I would  
22 focus on are points pertaining to facilities being at  
23 capacity, kids having to leave their communities to  
24 access services, the emergency departments not being  
25 an appropriate place to treat mental illness, the

1 ability to place emphasis on continuity of care when  
2 not having to send kids to Chattanooga and Knoxville  
3 and sometimes as far as Memphis."

4 Did I read that correctly?

5 A. You did.

6 Q. And those are sort of the talking points, if  
7 you will, that you sent out not only to Ms. Sanders  
8 but to a number of people in the community to try and  
9 get these letters of support; right?

10 A. Yeah. These were things that were all brought  
11 up as part of our conversations with the stakeholders.

12 Q. And the people you mentioned, the 25 people I  
13 think, or however many there were that wrote letters  
14 of support, none of them saw fit to come here to  
15 testify in this trial; right?

16 A. Right.

17 Q. Or to submit an affidavit; right?

18 A. Right.

19 Q. You also say in this email to Ms. Sanders,  
20 looking up a little bit farther up in that paragraph,  
21 "We have chosen to not be in Johnson City as to avoid  
22 a political war with Mountain States"; is that right?

23 A. That's right.

24 MR. JACKSON: That's all. You can give  
25 that to her. Thank you.

1 THE COURT: Are you wanting to mark that?

2 MR. JACKSON: Oh, yeah. I do want to  
3 enter these.

4 THE COURT: Exhibit 378 will be marked as  
5 the next exhibit. It is an email from Mr. Garone to,  
6 it looks like Lucretia Sanders. It's dated January  
7 23rd, 2014.

8 (Marked Exhibit No. 378)

9 BY MR. JACKSON:

10 Q. All right. Mr. Garone, you and Mr. Shaheen  
11 and your attorney, Mr. West, are the ones that came up  
12 with the service area in this case; right?

13 A. That's correct.

14 Q. And you didn't perform any kind of written  
15 analysis of historical patient patterns when you came  
16 up with that; right?

17 A. We did not.

18 Q. You didn't, for example, look to see where  
19 patients seen at Indian Path Psychiatric Pavilion --  
20 well, let me back up. You know that there was a  
21 psychiatric facility at Indian Path until 2009; right?

22 A. I do.

23 Q. You didn't, as part of your work in coming up  
24 with a service area, look to see and make any analysis  
25 of where those patients at that facility had come

1 from; true?

2 A. We did not do a written analysis of patient  
3 origins, if that's what you're asking.

4 Q. You didn't look to see where residents of  
5 Sullivan County were going currently to receive  
6 psychiatric care or make any analysis of that; did  
7 you?

8 A. Well, there's some mention of that within the  
9 JARS that are submitted to the state for area  
10 providers. We looked at that information, yes.

11 Q. You didn't sit down, though, and make any kind  
12 of analysis so that you could figure out what  
13 percentage of those patients you could capture with  
14 your new facility, for example?

15 A. There was no written analysis for that.

16 Q. You didn't hire an expert like Mr. Sullivan to  
17 do that kind of analysis for you; right?

18 A. No.

19 Q. You all estimate that there is going to be  
20 about 2,000 cases in the second year of the operation  
21 of this facility; right? Approximately?

22 A. Can I reference that? I think --

23 Q. Let me, just to save us time, I'll represent  
24 to you it's about 1,800 and some odd patients by year  
25 two. That sounds about right to you; doesn't it?

1 A. Okay.

2 Q. You and your colleagues never put pen to paper  
3 to project or estimate what counties any of those  
4 2,000 cases were going to come from; true?

5 A. No. We made the decision that based on the  
6 lack of availability within the counties within our  
7 service area and the population and looked at, you  
8 know, the population trends and utilization rates in  
9 our other communities, but no written analysis was  
10 done on the utilization per county for the new  
11 facility.

12 Q. Right. I mean, for example, you didn't  
13 project how many folks you thought were going to come  
14 down from Lee County to make up those 2,000 cases;  
15 right?

16 A. We did not project that.

17 Q. Or Wise County or Hawkins County, any of these  
18 counties, you didn't do that kind of county  
19 projection; true?

20 A. True.

21 Q. You didn't do any kind of formal analysis of  
22 out-migration? You know what out-migration is?

23 A. I do.

24 Q. You know that some people presumably are  
25 leaving your service area to get treatment in other

1 places; right?

2 A. Yes.

3 Q. You all didn't sit down and put pen to paper  
4 to figure out exactly what people are leaving Sullivan  
5 County, Hawkins County, or these counties in Virginia  
6 to seek treatment; did you?

7 A. What we -- in terms of out-migration, we  
8 looked at the information that was supplied to us by  
9 the Sullivan County Sheriff's Department and made  
10 the -- took that information, which led us to believe  
11 if one sheriff's department within one county within a  
12 five-county service area had that type of volume of  
13 out-migration, we felt comfortable that there was  
14 enough out-migration within the entire service area to  
15 represent a significant need.

16 Q. When you say out-migration, the place the  
17 Sullivan County Sheriff was mostly out-migrating to  
18 was Woodridge; right?

19 A. No, I was referring to the out-migration to  
20 Peninsula and Moccasin Bend.

21 Q. And so you took some information from a  
22 Sheriff, and that was the basis of your out-migration  
23 analysis. You assumed that would extrapolate to the  
24 rest of your service area; is that fair?

25 A. Proportionately, yes.

1 Q. There's no document that you all prepared  
2 where you ever examined the potential impact of your  
3 hospital on any existing provider; true?

4 A. There is no document that we created that  
5 would show the impact on any existing providers from  
6 our service area. No.

7 Q. Nobody at SBH has had any conversations with  
8 anybody at the State of Tennessee about caring for  
9 uninsured people that might have been seen at the old  
10 Lake Shore; true?

11 A. We had a conversation directly with the state  
12 about that. No.

13 Q. And you told me at your deposition it would  
14 make sense for those patients to continue to go to  
15 Woodridge because there is a reimbursement for them at  
16 Woodridge and not at your facility; true?

17 A. That's paraphrasing but, yes, in essence.

18 MR. JACKSON: That's all I have. Thank  
19 you, sir.

20 THE WITNESS: Thank you.

21 MR. WEST: Your Honor, I have very brief  
22 redirect.

23 REDIRECT EXAMINATION

24 BY MR. WEST:

25 Q. With regard to Mr. Jackson's questions to you

1 about the list the statistician -- he called him the  
2 Vanderbilt statistician, Mr. Thompson did, his  
3 analysis. You're familiar with what I'm talking  
4 about?

5 A. Yes, sir.

6 Q. And Mr. Jackson asked you about, I believe if  
7 my recollection is correct, that upper East Tennessee  
8 or whatever on the list was not number one in any --  
9 or number one on the list. Do you know sitting here  
10 what was number one and what its current status is?

11 A. Sure. The number one location on the list was  
12 College Station, Texas, to which we opened our  
13 facility in April of 2014.

14 Q. All right.

15 MR. WEST: That's all I have, Your  
16 Honor -- excuse me. That's all I have, Your Honor.

17 THE COURT: Anything further, Mr.  
18 Jackson?

19 MR. JACKSON: I'm sorry. No, nothing  
20 further.

21 THE COURT: All right. Mr. Garone, you  
22 can step down. Don't discuss your testimony or the  
23 exhibits with any other witnesses.

24 MR. GARONE: Thank you, Your Honor.

25 MR. WEST: Your Honor, I know we had

1 discussed yesterday using deposition testimony at this  
2 point, but I've been told that, for example,  
3 Ms. Bailey is here today and will be the next witness.  
4 Given that and further review of the depositions we're  
5 electing at this point in time to defer our exam --  
6 we'll just examine Ms. Bailey when she is on the stand  
7 when our time comes.

8 I did want to say to the Court formally,  
9 based on the record and the witness' testimony and the  
10 acknowledgment by all parties, that Mr. Sullivan is an  
11 expert. He's our expert, and his report is in the  
12 record, and many of his exhibits. That concludes our  
13 proof. We can take this other issue up about the  
14 affidavit issue with those other two witnesses later.  
15 But we have finished our proof a little early from our  
16 schedule.

17 THE COURT: Okay.

18 MR. JACKSON: Your Honor, just so I'm  
19 clear, he's resting his case, as I understand it,  
20 subject to the -- no, that's right, the affidavits are  
21 in our case.

22 THE COURT: He's finished his proof.

23 MR. JACKSON: He's finished his proof.  
24 Sorry.

25 MR. WEST: Yes, sir.

1 MR. CHRISTOFFERSEN: To the extent it  
2 won't come from other witnesses.

3 MR. WEST: Well, the record is still  
4 open.

5 Your Honor, if I may, can I suggest we  
6 take a brief recess to kind of get organized for the  
7 next witness?

8 MR. JACKSON: That's fine, Your Honor.

9 I did want to raise one issue. We did  
10 make -- we did make arrangements for Dr. Goodkin to be  
11 available this afternoon by 3:30 by telephone if  
12 Mr. West wanted to examine him. But I've talked to  
13 Mr. West, and my understanding is he would prefer to  
14 do it by later deposition and submit it, you know, to  
15 keep the proof open to the limited extent of these two  
16 witnesses and do that at a later date. I don't think  
17 I have any -- well, I need to confirm with  
18 Mr. Swearingen because I haven't dealt with these  
19 witnesses personally. So I just don't know how hard  
20 they are to get scheduled; so I need to kind of talk  
21 with him. I don't have any personal problem with  
22 that, but if the witnesses tell me that they don't  
23 want to do this two weeks from now, then I may have to  
24 do something else; so that's where we are with these  
25 affidavits at this point. I just wanted to make you

1 aware of that and maybe we can discuss it during our  
2 break. Maybe I can talk to Mr. Swearingen and then we  
3 can talk to Mr. West about it and report back to where  
4 we are when we resume.

5 THE COURT: So there is some initial  
6 meeting of the minds that you're going to depose or do  
7 your cross examination -- one of them is available  
8 today or both of them?

9 MR. JACKSON: Yes, sir, one is available.

10 THE COURT: One is available today, but  
11 you're not wanting to do it today, Mr. West?

12 MR. WEST: Your Honor, I think in terms  
13 of the flow of the week and the upcoming witnesses, we  
14 would prefer to do it at a mutually agreeable time or  
15 times with depositions. Our firm, for example, has an  
16 office in Johnson City. You know, we can certainly  
17 work with them there or at their place of business or  
18 wherever; so that's the current status of our  
19 discussions of what Mr. Jackson and I talked about  
20 this morning.

21 THE COURT: So that you would do it  
22 possibly next week and then submit it as a late-filed  
23 exhibit --

24 MR. WEST: Late-filed testimony.

25 THE COURT: Or as late-filed testimony?

1 I suppose it makes sense to do both of them at once if  
2 you're not going to do it on the phone and do it in  
3 person.

4 MR. JACKSON: Here is my problem.

5 Mr. Swearingen reminds me of this. I think that we  
6 can probably do this off the record.

7 (Off the record.)

8 THE COURT: Mr. Swearingen, you can call  
9 your first witness.

10 MR. SWEARINGEN: Yes, Your Honor. I will  
11 call Marlene Bailey, please.

12 MARLENE BAILEY,  
13 was called as a witness, and after having been first  
14 duly sworn, testified as follows:

15 DIRECT EXAMINATION

16 BY MR. SWEARINGEN:

17 Q. Can you please state your full name?

18 A. My name is Marlene Bailey.

19 Q. Ms. Bailey, you're a little soft spoken, so  
20 I'm going to have to ask you to raise the volume a  
21 little bit. Act like you're speaking to somebody in  
22 the back row. Okay?

23 A. Okay. Very well.

24 Q. Can you tell the Court a little bit about  
25 yourself: where you're from, your educational

1 background, and your work experience.

2 A. I was born and raised in upper East Tennessee.  
3 I'm from Johnson City, Tennessee. I have a Bachelor's  
4 degree in social work and some Master's courses in  
5 Business. I have been at Woodridge for 26 years.  
6 Prior to that, I did work with the Department of Human  
7 Services in adoptions, foster care, abuse and neglect  
8 cases.

9 I started at Woodbridge in 1989. They had  
10 opened in 1985, and I've been there the entire time  
11 since that time. I started as an admission  
12 coordinator working in intake and admissions at the  
13 hospital. Throughout the years my jobs and roles  
14 changed somewhat. I became admission manager, I  
15 became manager of other departments.

16 When Mountain States purchased Woodridge from  
17 Frontier Health in 2005, I then became the respond  
18 manager, patient resource manager, utilization review  
19 manager, discharge planner manager. There were a  
20 whole lot of jobs rolled into one. And then in 2009 I  
21 became the position that I have now: director of  
22 behavioral health programs, which includes all those  
23 other things, plus EVS, dietary, overall operations of  
24 the hospital.

25 Q. And if you could, just give me a little

1 snapshot of what your day-to-day operation looks like;  
2 what your real job responsibilities and duties  
3 typically are.

4 A. My duties have to do with patient flow, with  
5 making sure that everybody is doing everything they  
6 can to get the patients where they need to be in the  
7 hospital or out of the hospital if it's an out-patient  
8 service that they need. I'm making sure that the  
9 hospital is safe, working with our safety department,  
10 with our security, with environmental services, with  
11 engineering, just to make sure that the hospital and  
12 its operations is running the way that it should.

13 Q. And what kind of services does Woodridge  
14 Psychiatric Hospital offer?

15 A. Woodridge is an 84-bed hospital. We have five  
16 units and we offer services to children, adolescents,  
17 adults, geriatric. Those are psychiatric services.  
18 We also offer detox services.

19 Q. And has that been, essentially, the types of  
20 services Woodridge has offered since you've been  
21 there?

22 A. Yes.

23 Q. And does Woodridge also offer some out-patient  
24 services?

25 A. We also have some out-patient services. We

1 have intensive out-patient, we have some partial. We  
2 have some, you know, services like that.

3 Q. And what is Woodridge's mission as a  
4 psychiatric hospital?

5 A. Woodridge is really the safety net hospital in  
6 upper East Tennessee, and our main mission is to take  
7 care of the needs of the people, especially those  
8 people that no one else is going to take care of in  
9 their psychiatric distress.

10 Q. And you mentioned earlier that you've been at  
11 Woodridge for quite a long time. Woodridge hasn't  
12 always been owned by Mountain States; right?

13 A. That's correct.

14 Q. And you have worked both for the previous  
15 owners and Mountain States continuously?

16 A. Yes.

17 Q. Going back in time into history, how has  
18 Woodridge -- since you've been there starting in 1989,  
19 what has it felt like its obligations were to the  
20 community?

21 A. Well, originally Woodridge was owned by the  
22 community mental health center, so that really gave it  
23 the flavor of being a community hospital. That  
24 continued even after we became Mountain States. We  
25 continued to serve the needs of the community and not

1 just the local Johnson City/Washington County  
2 community, but the regional community is what I'm  
3 speaking of, the whole upper East Tennessee area and  
4 some of southwest Virginia also.

5 Q. And does Woodridge today have policies in  
6 place regarding charity care and indigent care?

7 A. Yes, we do. We have procedures to take care  
8 of patients who have no income or have no insurance.

9 Q. As we're speaking historically, Woodridge was  
10 purchased by Mountain States sometime in 2005; is that  
11 right?

12 A. Yes.

13 Q. Ms. Bailey, I've put a number of exhibits in  
14 front of you. Do you see one that's marked 246?

15 A. Yes.

16 Q. If you would turn to the first actual page of  
17 that document. The first page is just the cover, the  
18 second page shows some --

19 MR. SWEARINGEN: Your Honor, it's not in  
20 there. It's one of the ones that Mr. West made an  
21 exhibit. You can have my copy.

22 THE COURT: No, you keep it.

23 MR. JACKSON: Which one is this again?

24 MR. SWEARINGEN: It's 246.

25 THE COURT: It's already been made an

1 exhibit?

2 MR. SWEARINGEN: It has.

3 BY MR. SWEARINGEN:

4 Q. Ms. Bailey, were you at Woodridge in 2003,  
5 2004, 2005, and 2006?

6 A. Yes, sir.

7 Q. During that time, was there a psychiatric  
8 hospital operating in Kingsport, Tennessee?

9 A. Yes, Indian Path Pavilion.

10 Q. And leading up till 2005 before Woodridge was  
11 purchased by Mountain States, would they have been a  
12 competitor?

13 A. Yes, they were a competitor.

14 Q. Of the Woodridge facility that you were  
15 working at?

16 A. Yes.

17 Q. And what were the differences between the  
18 Indian Path Pavilion facility and what Woodridge was  
19 offering in the early 2000s?

20 A. Indian Path was a little bit more of an elite  
21 hospital for folks who -- more of the patients who had  
22 commercial private insurance tended to go to Indian  
23 Path than went to Woodridge. Woodridge was more of  
24 the hospital for the working class or the indigent or  
25 the TennCare Medicaid kinds of folks, plus Woodridge

1 also took patients who were sicker, had more needs.  
2 They were sicker, they had more acuity. We were able  
3 to handle those patients, and the Pavilion really  
4 wasn't.

5 Q. And was that difference in the types of  
6 patients that you were seeing, was that part of the  
7 mission that Woodridge has as the community hospital?

8 A. Yes, it was. When Woodridge was first built  
9 in 2085 [sic], part of the original mission was to  
10 help the state out. The state recognized that people  
11 from upper East Tennessee were going to have to go all  
12 the way to Lake Shore to get hospitalization, and they  
13 really hoped that we would build a hospital in upper  
14 East Tennessee and meet some of those needs; so the  
15 State was very instrumental in the building of  
16 Woodridge and funding some of those beds early on in  
17 the hospitalization. So that was very much a part of  
18 our mission.

19 Q. This document that I've put in front of you  
20 was testified about yesterday by a witness on behalf  
21 of SBH, Mr. Sullivan, the one that is Exhibit 246.  
22 The first column there you'll see on the first page,  
23 has down numbers of psychiatry patients in 2005; do  
24 you see that?

25 A. Yes.

1 Q. And I'll represent to you two things when  
2 asking these next questions. First, these are DRGs,  
3 psychiatry DRGs, for these particular facilities. My  
4 second representation would be that this is based  
5 on -- well, let me ask you this, did Woodridge, prior  
6 to its purchase by Mountain States, report to the  
7 Tennessee Hospital Association?

8 A. No.

9 Q. Prior to the purchase of Woodridge by Mountain  
10 States, would you expect discharges or admissions from  
11 Woodridge to be in a THA data base which records that  
12 kind of information?

13 A. I wouldn't, no, I wouldn't expect that,  
14 because we weren't reporting to THA.

15 Q. You were present at Woodridge in 2005 and  
16 2006; correct?

17 A. Yes.

18 Q. Do you recollect -- it says here 1,295  
19 patients in 2005 and then 2,883 patients in 2006. Do  
20 you recall a doubling of Woodridge's census between  
21 those two years?

22 A. No. I would imagine that really if you had  
23 the numbers of the census and the admissions and  
24 discharges, it would be very, very similar during that  
25 period of time.

1 MR. WEST: Your Honor, I would object to  
2 the witness testifying about what she imagines. I  
3 mean, she is a factual witness, not an expert. I  
4 respect Ms. Bailey's position and tenure, but I want  
5 to interpose that objection.

6 MR. SWEARINGEN: I think as a fact  
7 witness she can --

8 THE COURT: Well, if she has an  
9 explanation, if she thinks there is something with the  
10 numbers that, in her mind, based on her position, I  
11 think that she can speak to that. I don't think she  
12 was offering necessarily any type of --

13 MR. WEST: I understand.

14 THE COURT: -- a speculative, which would  
15 be the basis of your objection.

16 MR. WEST: That's true. You said the  
17 term imagine makes me believe it's speculative.

18 THE COURT: All right. And maybe,  
19 Mr. Swearingen, maybe you can clean that up.

20 MR. SWEARINGEN: I can clean it up a  
21 little bit.

22 BY MR. SWEARINGEN:

23 Q. Ms. Bailey, does it appear accurate to you  
24 that Woodridge would have seen 1,295 patients in 2005?

25 A. No, that seems inaccurate, and seems to be

1 only a part of that year.

2 Q. I'm not asking you for a specific number, but  
3 let's say in 2004, do you have an idea of an estimate  
4 of how many patients would have been admitted to  
5 Woodridge in 2004?

6 A. 2004-2005, probably at least 2,500.

7 Q. That's all the questions I have about this  
8 document for you, Ms. Bailey. I want to take you  
9 back, or I guess move forward a little bit in time, we  
10 were talking about 2005 and 2006. There also was an  
11 event that occurred in 2012 that impacted Woodridge;  
12 is that correct?

13 A. Yes.

14 Q. And what was that event?

15 A. That was when Lake Shore closed in 2012.

16 Q. Describe for the Court what happened in 2012  
17 and how Woodridge was approached about that.

18 A. Well, in late 2011 Woodridge was actually  
19 approached about the pending closure of Lake Shore.  
20 And we were asked, because we already were taking  
21 patients from the area trying to prevent them having  
22 to go to Lake Shore, we were asked to take more  
23 patients to increase our census. The anticipated  
24 number of patients that the state thought we should  
25 take in addition to what we were taking was about ten

1 more patients. And they even outlined an area that  
2 extended beyond what we were currently taking,  
3 expecting us to take down more into Hamlen County and  
4 down a little bit more toward the Knoxville area in  
5 East Tennessee.

6 So they approached us about that, and  
7 Woodridge administration, Mountain States, was willing  
8 to do that. So we started making plans for additional  
9 staff, figured out how many additional staff we would  
10 need, what additional services we would need,  
11 security, those sort of things; so we started doing  
12 that. And, actually, because they were going to be  
13 closing by the end of year 2012, their fiscal year at  
14 the end of June of 2012, after the state announced to  
15 the lecture staff and administration that they would  
16 be closing, really Lake Shore started taking fewer and  
17 fewer patients because they weren't going to be able  
18 to maintain the staffing and the treatment; so we  
19 really started taking those patients. We worked very  
20 collaboratively with Frontier Health during that  
21 period of time, the local community mental health  
22 center, and we actually started in January and  
23 February of that year taking more patients than we  
24 currently had.

25 Q. And were the negotiations between Mountain

1 States and the State of Tennessee about how these  
2 additional patients you would be seeing that were  
3 previously being seen at Lake Shore, how Woodridge and  
4 Mountain States would be compensated for those?

5 A. We were already receiving some grant funding  
6 from the state, and they talked about additional  
7 funding until the next fiscal year started so they  
8 would help us out with the payment, because we were  
9 willing to take more patients for them.

10 Q. And did Mountain States and the State of  
11 Tennessee ultimately enter into a grant agreement to  
12 cover these patients?

13 A. They did enter into a grant agreement for  
14 those patients.

15 Q. Explain to the Court how that grant operates  
16 and works on an annual basis.

17 A. The grant is \$2,548,240, give or take. Two  
18 and a half million dollars. The grant is paid out  
19 monthly regardless of how many patients we take. We  
20 send reports in monthly and annually about the  
21 patients we take. A lot of demographic information  
22 about those patients, their length of stays, their  
23 diagnosis, all sort of things about them, their home  
24 environment, their race, their sex, everything. We  
25 send a very detailed report into the state monthly,

1 and they pay us one-twelfth of the grant each month.

2 Q. And is that payment based on the number of  
3 patients or simply based on the fact that it's  
4 one-twelfth of the total year?

5 A. It's based on one-twelfth of the total year  
6 regardless of how many patients we take, unless we  
7 take fewer patients, which we never do. But if we  
8 were to take fewer patients, they would probably have  
9 paid us less than one-twelfth.

10 Q. Well, that was going to be my next question.  
11 What has your experience been, since this has been  
12 instituted since 2012, what has your experience been  
13 as it relates to the volume of the patients that  
14 they're seeing that are grant eligible?

15 A. Actually, there are always more patients than  
16 the grant covers. Even after we know that the grant  
17 is no longer going to cover, because of our mission  
18 and our service to the community, we continue taking  
19 the patients and meeting their needs when we have the  
20 beds available so that they can stay in the local  
21 community.

22 Q. And since Woodridge began accepting these  
23 grant patients in 2012, has the grant run out every  
24 year?

25 A. Oh, yes. Every year.

1 Q. And what happens when the grant runs out?

2 A. Well, we can go talk to the state and ask  
3 them, you know, and tell them how much more -- of  
4 course, they know, because every month we bill for the  
5 total amount, and they know that we're going to bill  
6 for the total amount even though they're only going to  
7 pay us the one-twelfth; so they're aware of how many  
8 more patients we are taking.

9 Q. And since the grant has been in operation and  
10 you've had these overages, have you been able to  
11 successfully negotiate with the state for some  
12 additional compensation?

13 A. Sometimes, yes.

14 Q. I wanted to talk a little bit about the  
15 admission process at Woodridge and give the Court some  
16 background on how the process works up in upper East  
17 Tennessee.

18 How are patients -- how do they present or how  
19 are they referred to Woodridge?

20 A. Most of the patients that we receive are seen  
21 in an emergency department or on a medical floor of a  
22 hospital. We can take walk-ins at Woodridge and do  
23 that, but most of our referrals come either from our  
24 own hospitals, and by that I mean Mountain States  
25 hospitals. In the case of Mountain States hospitals,

1 we have a crisis team located at Woodridge called  
2 Respond, which sees most of those referrals. And then  
3 for the patients who are indigent -- one of the terms  
4 of the state grant is -- one of the clauses in there  
5 is if there is an indigent patient who is eligible  
6 financially for the state grant, the community mental  
7 health center has to see and evaluate that patient and  
8 determine their need for the hospital, not Woodridge;  
9 so we will call the community mental health center if  
10 it's a person who appears financially that they might  
11 be eligible for the state grant funding; so we work  
12 very closely with Frontier Health, and they come into  
13 our hospitals and see those patients and then refer  
14 them to inpatient, out-patient, whatever the patient  
15 needs.

16 Q. And that nuance about Frontier Health having  
17 to see the patients and not you all, is that because  
18 they don't want there to be any perceived  
19 self-referral type basis?

20 A. Yes, that's exactly what it is.

21 Q. Are there state guidelines in place about how  
22 quickly somebody who, say somebody like me, a  
23 34-year-old male presents to the emergency room -- not  
24 airing any dirty laundry here -- just hypothetically,  
25 shows up in an emergency room in Johnson City. Are

1 there guidelines in place about how quickly that  
2 person -- and that person is in some sort of  
3 psychiatric distress -- are there guidelines in place  
4 about how quickly that person needs to be seen?

5 A. Yes, there are. The state has put a guideline  
6 in place for the crisis teams that they should see  
7 that person within two hours.

8 Q. And do you know the Respond team, which is  
9 Woodridge's responsive efforts to evaluate these  
10 people in hospitals, do you know on average how  
11 quickly they see patients here in emergency rooms?

12 A. Our average is 30 minutes.

13 Q. Once someone presents to the hospital and is  
14 evaluated, what is the process of getting that  
15 individual admitted into Woodridge or any other  
16 psychiatric provider in northeast Tennessee?

17 A. Okay. Let me tell you something else about  
18 referrals that I neglected to say. Many of our  
19 referrals come from outside Mountain States system,  
20 obviously. So Frontier Health or our community mental  
21 health center may see those people in another  
22 hospital, and then they do an evaluation and then send  
23 that information; so whichever way we collect the  
24 information, if sent from the outside in, we call  
25 those direct referrals, or if Respond does the

1 evaluation we have an evaluation in the computer  
2 online or in a paper format. We present that  
3 information to our psychiatrist, and actually for the  
4 folks that are in -- the patients that are in Mountain  
5 States, whether the patient is going to be admitted or  
6 not admitted, we present the information to the  
7 psychiatrist for their input; so we present the  
8 information, give the diagnosis, explain what's going  
9 on with the patient. If we're asking for inpatient  
10 hospitalization, we're explaining why a lesser level  
11 of care wouldn't work or hasn't worked, perhaps has  
12 failed, and then the doctor advises us as to what we  
13 need to do from there.

14 Q. And can this process take, this evaluation  
15 process, take some time?

16 A. Sure. If you have a two-hour wait before the  
17 patient is even seen, an evaluation itself takes 45  
18 minutes to an hour. A lengthy one, an extended one  
19 for a difficult situation, may take an hour and a  
20 half. If you're trying to obtain collateral  
21 information from someone else, maybe you want to do  
22 that from maybe the police department who brought the  
23 patient in or from a family member; so those things  
24 can add. You're waiting for a medical clearance on  
25 the patient if that patient is in a medical setting.

1 Then you talk with the doctor, which that part doesn't  
2 take very long, they are very responsive and call us  
3 right back. And then you report back to the mental  
4 health center if they're the ones who referred the  
5 patient, or the Respond folks take care of talking  
6 with the nursing staff and making arrangements for the  
7 patient to be transported to Woodridge or wherever  
8 they're going.

9 Q. While a patient is going through this  
10 evaluation process, either in the emergency room or  
11 whatever setting they're being evaluated, are they  
12 also receiving treatment during that time?

13 A. The patients are receiving treatment. The  
14 patients are being kept safe. They very often have a  
15 sitter assigned to them. That's at the doctor's  
16 discretion. Most often if a patient goes into an  
17 emergency room or is in a hospital room or is in a  
18 hospital setting because of some sort of attempt, they  
19 will have a sitter assigned to them. The physicians  
20 may start medication.

21 Now, if the patient is in the hospital setting  
22 for a little while, the physician in the hospital is  
23 definitely going to start medication, they're going to  
24 start a treatment plan, they're going to ask for a  
25 psychiatric consult from a psychiatrist. We also run

1 a psychiatry consult liaison service. There may even  
2 be -- if for some reason there was a very extended  
3 period of time, there could even be therapy offered  
4 that we would do too.

5 Q. We spoke a little bit about the closure of  
6 Lake Shore and the influx of those patients into  
7 Woodridge. Did that closure and these new patients  
8 that were seen at Woodridge, starting in 2012,  
9 bleeding into 2013 through today, did that cause any  
10 operational issues at Woodridge?

11 A. Well, it caused us to use more beds, be  
12 busier, have a larger census on any given day, more  
13 acuity. The patients that we are receiving today are  
14 more acute. And by that I mean they're more  
15 difficult, they have more extensive problems, and may  
16 require closer levels of watching than the patients  
17 that we might have had before. There are more of  
18 those kinds of patients. Let me say it that way.

19 Q. We saw some documents yesterday that were  
20 admitted as exhibits that talk about deferrals that  
21 have occurred at Woodridge.

22 A. Yes.

23 Q. Explain what a deferral is.

24 A. A deferral is a patient that we can't take at  
25 that moment in time for whatever reason, so we are

1 trying to make other arrangements for that patient so  
2 they can get a bed. It doesn't mean they're not going  
3 to get treatment. They are going to get treatment  
4 either at our hospital at a later time or they'll be  
5 referred to another community resource.

6 Q. For instance, we've seen some documents that  
7 show that individuals were deferred because of medical  
8 reasons?

9 A. Correct.

10 Q. In your experience, someone who is deferred  
11 for a medical reason, what ends up happening with  
12 those patients?

13 A. Generally if they're deferred for a medical  
14 reason, after the medical reason is cleared, which  
15 could be anywhere from hours to days, then they're  
16 re-presented, they're reevaluated. They would be  
17 reevaluated and if need be, they would be re-presented  
18 and perhaps taken at that time.

19 Q. And, similarly, someone who presents for a bed  
20 and is deferred because no bed is available at that  
21 time, is it possible that Woodridge would still see  
22 that patient at some point?

23 A. Yes, because we may have a bed a few hours  
24 later or the same day. We may have a bed available  
25 at, you know, a later time. They may stay in the

1 emergency room and start receiving treatment there or  
2 stay on the floor and start receiving treatment and  
3 then be re-presented and we have a bed. That is  
4 another place where we stay in really close  
5 communication with Frontier Health.

6 I refer to Frontier Health so much because  
7 that's the community mental health center for our  
8 region and the one we work with the most. We work  
9 with other mental health centers, too, but we have  
10 conversations every morning and all day long about bed  
11 availability with Frontier Health. They update us on  
12 where patients are and what their needs are, and we  
13 update them on our situation so that, you know, when  
14 beds become available we can get those folks in.

15 Q. You also communicate with other providers in  
16 northeast Tennessee to determine what their bed  
17 availability is?

18 A. Yes, we do. We are in communication with  
19 Peninsula, which is in Knoxville. We are in  
20 communication with the Bristol hospitals, there are  
21 two hospitals available, in-patient facilities; in  
22 Greeneville Takoma Senior Care. We communicate with  
23 them all regularly also.

24 Q. And since 2012 or 2013, even early 2014, has  
25 Woodridge taken steps to try to increase its

1 efficiency?

2 A. Oh, many steps, yes.

3 Q. Describe for the Court a few of the things  
4 that you all have done.

5 A. In early 2014, Woodridge participated in a  
6 lien adventure. And for Mountain States it's  
7 called -- first we had a value stream analysis to  
8 determine what some of the needs were, and out of that  
9 we had a rapid improvement event. And a rapid  
10 improvement event for us for this particular event was  
11 a week-long event in which two of our psychiatrists,  
12 our administrator, Dr. Dru Malcolm, myself, an  
13 emergency room director and a facilitator, and one  
14 more person, the clinical leader of the Respond team.  
15 We all participated for a week in determining how we  
16 could better serve our emergency rooms.

17 The focus of that rapid improvement event was  
18 Indian Path Medical Center emergency room. They're  
19 the hospital that asked for it, but we soon actually  
20 changed the location and came to Woodridge and worked  
21 out our issues from Woodridge so they could see what  
22 Woodridge issues were and we could better help them.

23 Now, it disseminated to all of our emergency  
24 rooms, the things that came out of that. We studied  
25 length of stays, communication with doctors, nurses

1 and doctors talking to each other, nurses and Respond  
2 talking to each other. But out of that rapid  
3 improvement event, we really came down with some real  
4 ways of making things move faster, easier. Some  
5 examples would be using telemedicine instead of  
6 driving to Indian Path to see the patient so that you  
7 could shave off some time at the beginning of the  
8 evaluation and make that patient's wait time less.  
9 Even using the telemedicine if the doctor needed to  
10 see the patient, not just the crisis team.

11 The crisis team people in Tennessee, both  
12 Respond and the Frontier Health crisis team, are  
13 Master's level clinicians who are able to do  
14 commitments. They're able to see people, make  
15 diagnoses and do a commitment on a person if a person  
16 is unable to sign themselves into the hospital or  
17 unwilling, and yet they've proven that they need to be  
18 in the hospital. So we worked with these clinicians  
19 and figured out -- we even included Frontier Health in  
20 some of this rapid improvement event to find ways to  
21 better facilitate treating a patient in a timely  
22 manner.

23 Some of the other things that we did during  
24 early 2014, we started a bed huddle, which sounds like  
25 a real simple thing? Every day -- and we have

1 continued this on, we have held the games through  
2 today -- the doctors, all of our psychiatrists with  
3 Mountain States Medical Group, and our nurse managers,  
4 and several of our administrators, meet daily in the  
5 Respond area. We have a large white board about the  
6 size of that screen on which we can see the patient  
7 flow. We can tell who's coming, who's going, who is  
8 being discharged, who needs a private room, who is  
9 going to be discharged tomorrow even. We really do a  
10 lot of just nitty-gritty planning in about ten minutes  
11 time. But having the doctors there has made a huge,  
12 huge difference.

13 Another thing that we did was that we started  
14 a patient flow sheet so that first thing in the  
15 morning Respond would know, okay, do we have people  
16 waiting, do we have beds available so that we can all  
17 be on the same page. It's a very informal sheet of  
18 information, but it tells us where we are and what  
19 we're going to work on during that day, getting  
20 patients moved, getting patients flowing in the  
21 direction they need to go.

22 Q. On that subject, Ms. Bailey -- I'm not going  
23 to make you look through all of these. I'll represent  
24 to you that an exhibit has been made of some patient  
25 flow sheets. There has been quite a bit of discussion

1 about these over the last couple of days. You just  
2 described it a little bit, but is this a patient flow  
3 sheet?

4 A. That's a patient flow sheet.

5 Q. And what is the purpose of this?

6 A. It's a worksheet for Respond to work with the  
7 physicians and just to know, I mean, it's just -- it's  
8 a list of people -- in front of you it's a list of  
9 what you have available and who needs a bed right then  
10 at that moment. It's usually about 7:00 or 7:30 in  
11 the morning. It's just a worksheet, that's all it is.  
12 It's not a census. We have a separate census that is  
13 our official census that is recorded. This is just  
14 for response purposes only.

15 Q. And how many discharges on an average day  
16 would Woodridge have?

17 A. Fifteen.

18 THE COURT: Mr. Swearingen, for the  
19 record, why don't you identify what you've shown the  
20 witness.

21 MR. SWEARINGEN: 238, Your Honor, I  
22 believe is the number. I apologize.

23 THE COURT: Thank you.

24 BY MR. SWEARINGEN:

25 Q. Fifteen or so discharges?

1 A. Fifteen or so. Some days less, some days  
2 more.

3 Q. How do those progress over the course of a  
4 morning?

5 A. Well, the first thing in the morning when I do  
6 rounds, I talk to the units about who they know will  
7 be discharged. Every morning every unit has what we  
8 call a treatment team, and that is the physician, the  
9 discharge planner, the charge nurse, the therapist.  
10 Anybody of -- the utilization review person, that's  
11 the insurance person. They're all meeting about all  
12 of the patients. And by the time that treatment team  
13 is done, they know who is going to be discharged that  
14 day. The doctor hasn't seen the patients yet, but  
15 they know who is going to be discharged that day; so  
16 that's kind of the next step in the discharge process  
17 for us.

18 For Respond, either the physician himself or  
19 the nurse will call Respond and say, okay, this is the  
20 number of discharges that we think we'll have. So we  
21 go to our whiteboard and we mark those people as  
22 discharges so that we know we're going to have those  
23 beds; so when we know we're going to have a discharge  
24 then we start planning for a particular person to come  
25 in the hospital.

1           Now it's not simply I discharge one, I admit  
2 one. If you discharge one on Cedar, you can't admit a  
3 person who needs Poplar to Cedar, because their units  
4 are very different and have very distinct identities;  
5 so we have to make sure that the person that's coming  
6 in is getting to the right bed on the right unit.

7 Q.       Have the improvements that you were talking  
8 about that Woodridge has tried to implement, has that  
9 led to an increased census at your facility?

10 A.       We do have an increased census, yes.

11 Q.       And what is the average daily census that  
12 Woodridge is running about these days?

13 A.       Average daily census through the end of July  
14 was 72.

15 Q.       And on a percentage basis, do you know what  
16 that is?

17 A.       I think that's around 85 percent.

18 Q.       Do you consider that a good thing or a bad  
19 thing?

20 A.       I think it's a good thing.

21 Q.       Why?

22 A.       Because it means that for the patient's sake  
23 we're flowing the patients through. We're getting  
24 them into the hospital when they need to be in the  
25 hospital. You know, as we discharge patients and

1 re-admit more patients, we're meeting the needs of the  
2 patients, the emergency rooms, the law enforcement,  
3 the mental health centers, the community.

4 Q. Do you consider Woodridge to be overwhelmed if  
5 it's running at 85 percent census?

6 A. No.

7 Q. And why is that?

8 A. Because we're also meeting a lot of our goals.  
9 We're meeting our quality measurements that we need to  
10 keep up with. Psychiatric hospitals have what's  
11 called HBIPPS. It's hospital based in-patient  
12 psychiatry scores, those are measurements of how the  
13 doctors are doing. Our last measurement on that was  
14 98.6 percent, which is a very high, obviously,  
15 measurement for that.

16 Our patient satisfaction scores, we subscribe  
17 to Press Ganey satisfaction surveys. We have a large  
18 number of surveys that are returned to us, and in  
19 those patient satisfaction surveys we are  
20 94.8 percent, which is very good for a psychiatric  
21 hospital. Those measure everything from were you  
22 satisfied with your doctor, did you like the food,  
23 your discharge planners, were people nice to you, was  
24 it clean. I mean, there are pages upon pages of  
25 questions that our patients are asked. So that's a

1 very high score.

2 Another thing, our restraint rate is very,  
3 very low, and we pride ourselves on having a very low  
4 restraint rate. The national standard is .40 per  
5 1,000 patient hours, and ours is .02. We train  
6 everybody who works in Woodridge in HELP, which is  
7 Human Empowerment Learning Principles. It's a  
8 deescalation technique so that you don't go for  
9 restraints first thing. You talk to people. You try  
10 to prevent things before they happen. When you see  
11 that a patient is escalating, that they're irritated,  
12 maybe they're not getting the medication they want or  
13 they think it's not working, you sit down and talk to  
14 them. All of our employees, even our dietary, our  
15 EVS, our engineering, our admitting folks, everybody  
16 is trained in that.

17 Q. And by restraint rate, do you mean that  
18 they're involuntarily confined or restricted?

19 A. Involuntary restrained to a bed in four-point  
20 restraint.

21 Q. And have you seen any change in your deferral  
22 levels from 2013 to 2015?

23 A. Yeah, since 2013 I think our deferral levels  
24 are probably half what they were in 2013.

25 Q. You spoke a little bit about this before, but

1 even patients in July of 2015 were being deferred, are  
2 they receiving care?

3 A. Oh, yes, they're receiving care.

4 Q. And people who are on a wait list to get a bed  
5 as indicated on some of these flow sheets, are they  
6 receiving care?

7 A. They're receiving care. If they're waiting in  
8 a hospital they're receiving care.

9 Q. Ms. Bailey, do you think that there is a need  
10 for a new 72-bed psychiatric facility in Kingsport,  
11 Tennessee?

12 A. No, I do not.

13 Q. Do you feel like Woodridge is actively, not  
14 just Woodridge, but Woodridge and all of the other  
15 community partners out there in northeast Tennessee  
16 and southwest Virginia, do you feel like they and you  
17 are meeting the needs of the community?

18 A. I do feel that we are.

19 MR. SWEARINGEN: That's all my questions  
20 right now.

21 THE COURT: Cross-examination.

22 MR. WEST: Let me take just a moment,  
23 Your Honor. I've got some things to arrange here.

24 CROSS-EXAMINATION

25 BY MR. WEST:

1 Q. Good morning, Ms. Bailey. I'm Bill West. You  
2 and I met a couple of months ago at your deposition.

3 A. Yes.

4 Q. All right. I wanted to give some background  
5 here to some of the things that you were examined by  
6 Mr. Swearingen on, at least at first. You had spoken,  
7 and I think it's common knowledge, that there is a  
8 grant from the State Mental Health Department that  
9 pays for certain patients at Woodridge?

10 A. Yes.

11 Q. And I believe in your deposition I made that  
12 an exhibit, if I'm not mistaken. Your Honor, I'll  
13 take just a moment here. I have multiple copies. I'm  
14 having to separate them, if I may. I'm going to show  
15 you a copy of a document that was made Exhibit 53 to  
16 your deposition. I think we talked at some length in  
17 your deposition about it.

18 A. Yes.

19 Q. And is this document the grant contract that  
20 paid for patients at Woodridge from the Mental Health  
21 Department for the years 2012, '13, and '14?

22 A. Yes, it is.

23 Q. And who is the entity or what entity is the  
24 state contracting with?

25 A. Mountain States Health Alliance.

1 Q. So the contract is not with Woodridge per se,  
2 is it? It's with Mountain States?

3 A. It is with Mountain States for services at  
4 Woodridge, yes.

5 Q. And is Woodridge mentioned on the first page  
6 of the grant?

7 A. I'm sorry. You mean the front page?

8 Q. I mean, the front page of the document, the  
9 exhibit.

10 A. No, I don't see it. Woodridge is a department  
11 of Mountain States Health Alliance.

12 Q. Well, it's actually a department of Johnson  
13 City Medical Center; isn't it?

14 A. It is a department of Johnson City Medical  
15 Center, yes.

16 Q. And I think at your deposition you said the  
17 chief nursing officer that you report to is the chief  
18 nursing officer at Johnson City Medical Center?

19 A. Yes.

20 Q. If you look at the first page, the next page  
21 after the title page, it's Mountain States  
22 Document 1138. In the section A.2. there, what does  
23 it say about what individuals are covered by the  
24 grant?

25 A. Under b?

1 Q. A.2.b. Yes, ma'am.

2 A. Do you want me to read that?

3 Q. Well, not the whole thing, but it covers  
4 uninsured individuals?

5 A. Yes.

6 Q. And section A.2.b, how does it define an  
7 uninsured individual for purposes of this grant?

8 A. It does not have an identifying third-party  
9 health benefit payor source, has insurance but the  
10 insurance doesn't cover inpatient psychiatric  
11 services, has exhausted the benefits for inpatient  
12 psychiatric services or does not have any other  
13 financial means for inpatient psychiatric services.

14 Q. Thus, this contract that Mountain States has  
15 with the Department of Mental Health, to me anyway --  
16 and I wanted to ask you if this is accurate.  
17 Technically you don't have to be indigent in terms of  
18 the federal poverty rate. You can fall into any of  
19 these categories. You might be indigent under the  
20 federal poverty rate, but you could also be working at  
21 a job that doesn't have adequate insurance or your  
22 insurance may have been exhausted; is that right?

23 A. That's true, according to this.

24 Q. So a lot of times in the discussion -- in this  
25 case I'll represent to you that people talk about this

1 grant covering the indigent, and it's true that it  
2 does, but is it also true that it covers people who  
3 may not technically be indigent in terms of the  
4 federal poverty rate?

5 A. It's true, according to this definition, yes.

6 Q. All right. And the next section I think will  
7 reflect what we've been talking about, some of the  
8 other questions in this matter. The patient day runs  
9 midnight to midnight. Is that what it says?

10 A. Yes.

11 Q. All right. In your responses to  
12 Mr. Swearingen's questions, you spoke of Frontier,  
13 which I think you said is the community mental health  
14 center; is that correct?

15 A. Yes.

16 Q. And let me back up and interject, Frontier  
17 through a predecessor corporation actually established  
18 Woodridge; is that correct?

19 A. Yes.

20 Q. Was it called the Watauga?

21 A. Watauga Mental Health Center was the original  
22 owner of Woodridge.

23 Q. All right. And they either became or merged  
24 into Frontier; is that correct?

25 A. They merged with two other companies and

1 became Frontier, two other community mental health  
2 centers.

3 Q. Okay. Let's see. You had mentioned in  
4 response to Mr. Swearingen's questions that Frontier  
5 evaluates the indigent patients; is that correct?

6 A. Yeah, and probably the uninsured would have  
7 been the better term.

8 Q. So it's not just the indigent that Frontier  
9 evaluates for admission under the contract?

10 A. Those are the ones that are readily identified  
11 for them to evaluate. When we first know about an  
12 evaluation to be done, for instance, if a person had  
13 insurance, we may not know that they don't have  
14 psychiatric coverage or that they're underinsured at  
15 that time.

16 Q. But if they weren't indigent under the federal  
17 poverty guidelines, would they be admitted under this  
18 contract?

19 A. If they were indigent?

20 Q. If they were not.

21 A. If they were not indigent, they are admitted  
22 according to the terms of the contract, not according  
23 to the federal poverty guidelines.

24 Q. I know, but you just mentioned you may not  
25 know about their insurance status.

1 A. Right.

2 Q. So if their insurance is defective, and I mean  
3 defective in the sense it doesn't cover it, but  
4 they're not poor -- excuse me. Indigent under the  
5 federal poverty guidelines, what happens to their  
6 admission under the contract?

7 A. We arrange with the state. If that situation  
8 were to happen, that then we would talk locally with  
9 the community mental health center, and they could  
10 come to Woodridge and evaluate that person even after  
11 they got there and determine if they felt they needed  
12 to be there and then proceed according to the  
13 contract.

14 Q. And what happens if a person gets admitted  
15 through this process but it's later determined they do  
16 have insurance coverage, what happens to the insurance  
17 revenue?

18 A. It actually gets turned around and we would  
19 pay it back to the state if the state had reimbursed  
20 us under this, but then we somehow find out that there  
21 is insurance. There are checks and balances on that.  
22 We haven't yet found one, but if we were to find one,  
23 we would reimburse.

24 Q. The contract provides that it is sort of a  
25 setoff in a way. Doesn't this grant contract provide

1 that if that did occur, then Mountain States would  
2 refund those revenues back to the mental health  
3 department?

4 A. Exactly. Back to the state.

5 Q. In your prior testimony when you were speaking  
6 about having discussions with the state, I think it's  
7 now called the Tennessee Department of Mental Health  
8 and Substance Abuse Services; is that correct?

9 A. Yes, yes.

10 Q. It's changed its name several times over the  
11 course of these documents?

12 A. It has.

13 Q. And since this document was executed, I assume  
14 that the fiscal years that the state has are the same  
15 as the fiscal years for Mountain States?

16 A. Yes. July through June.

17 Q. July 1 through June 30th of the following  
18 year. And is there still a grant contract?

19 A. There is.

20 Q. Is it higher than this amount of 2.5 or 2.8  
21 million now?

22 A. No, it's the same amount.

23 Q. All right. And the 2012 number is much lower,  
24 that's because it was a partial year; is that correct?

25 A. Yes.

1 Q. And you had said, and I think it's reflected  
2 in Exhibit 53, that there are periodic reports, I  
3 guess they are monthly reports really, that Woodridge  
4 or Mountain States has to provide to the state just so  
5 the state will know what's going on with the grant  
6 program?

7 A. Correct.

8 MR. WEST: Your Honor, if I may, I would  
9 like to make this the next -- that is an exhibit. I  
10 just want to enter it into the record, Exhibit 53.

11 THE COURT: It hasn't been made an  
12 exhibit yet?

13 MR. WEST: Right, not in this process.  
14 It's an exhibit to the deposition, but we can retain  
15 that number, Exhibit 53. If you would hand that to  
16 the judge, please, Ms. Bailey.

17 THE COURT: Thank you.

18 (Marked Exhibit No. 53.)

19 THE COURT: Exhibit 53 will be marked as  
20 the grant contract, has a date of April 1st, 2012  
21 through June 30th, 2014.

22 BY MR. WEST:

23 Q. Ms. Bailey, I'm going to hand you a document  
24 that was used in your deposition as Exhibit 66 to  
25 Ms. Bailey's deposition. I think it actually consists

1 of two different kinds of documents. If you could go  
2 through that and identify them for the record, please,  
3 ma'am.

4 A. The first part is the date of directory.  
5 These are sort of the explanations and the codes that  
6 are used in order to fill out the latter part of the  
7 document, which is part of the monthly report that  
8 goes to the state.

9 Q. All right. And are you the person who has to  
10 do this?

11 A. No, it takes a host of people to do this.  
12 Actually, our utilization review department, the folks  
13 who work in insurance are in contact with the state on  
14 patients that are under this plan, fill out this and  
15 try to keep it concurrent through the month.

16 Q. And the cover page, which has the exhibit  
17 number on it, marked as Mountain States MSHA  
18 Document 1195, the lower right corner.

19 A. Yes.

20 Q. Now, after the -- it looks like it's called a  
21 data dictionary or whatever. After that section, what  
22 is the more intense chart that comprises the last two  
23 pages of this document?

24 A. Those are the -- that's the actual report that  
25 Woodridge sends to the Department of Mental Health.

1 Q. So this is an actual report it looks like for  
2 the month of August 2014. Does that look appropriate  
3 to you?

4 A. I'm sorry. I can't see it that well. If you  
5 say so. It's small.

6 Q. Well, it has a column called date of admission  
7 for the patients, and it appears to start at 7:20,  
8 July 20, 2014.

9 A. Okay. I've got that now.

10 Q. And the last -- so it appears to start on  
11 July 20th and it ends on August 31st, 2014?

12 A. Right.

13 Q. So it's a little bit more than a month?

14 A. Right. The way the reports are divided up, if  
15 you are still in the hospital at the end of the month,  
16 you would go over into the next month's report, and  
17 that's why you have some July folks on there.

18 Q. And if you'll look at the per diem, the far  
19 right side of this document, the per diem rate, what  
20 is that? The next to the last column on the right.

21 A. That is the amount -- if you were to divide  
22 out, take your one-twelfth, your monthly fee, and then  
23 divide it, it's per day. They will pay \$450 per day  
24 for the first patient. 400 which is an adolescent.  
25 \$477, that's the amount per day they pay per patient,

1 not to exceed one-twelfth of the grant in a month.

2 Q. So it's a little bit less -- the per diem is a  
3 little bit lower for adolescents than it is for  
4 adults?

5 A. It is.

6 Q. So within the accounting system of Mountain  
7 States then, the per diem rate that's looked at for  
8 these patients is for adults \$477 per day?

9 A. Yes.

10 Q. Is that still true?

11 A. Yes -- no. I'm sorry, that's not true. The  
12 new grant that came out in 2015, they agreed to pay us  
13 more. I don't know the exact amount, but the total  
14 overall was not more. So, therefore, fewer patients  
15 could take advantage of the grant. For instance, they  
16 were going to pay us \$500. I don't know what the  
17 amount is, so that meant not as many patients would  
18 receive the grant, but your total amount would still  
19 be the overall monthly amount and annual amount.

20 Q. All right. But within your accounting system  
21 you could recognize a higher per diem than 477 for an  
22 adult patient under the new grant?

23 A. Yes.

24 Q. All right. And if you'll look at the very end  
25 of the document, the very last page. Read those.

1 There's some small print, but it's not in the graph.  
2 It's a little easier to read, the last three lines.  
3 Can you identify -- can you look at that and tell us  
4 what that means?

5 A. That means that we use 200,000, and I think it  
6 says 44,000 and something for that month, which was an  
7 overage of 33,000 for this particular month of August.  
8 We spent 33,000 more on patients than the grant would  
9 provide.

10 Q. All right. And it also gives the per diem  
11 rate on the right-hand side then?

12 A. Yes.

13 Q. So it's a little bit -- the per diem rate  
14 looks to be slightly lower than 477 for adults?

15 A. It does. And I'm not sure why it says 464. I  
16 don't know why it says 464 there, 477.

17 Q. And it also gives you the total number of  
18 patient days for that month under the grant?

19 A. Yes, uh-huh.

20 Q. And what is that for August 2014?

21 A. I believe it says 912.

22 Q. 512?

23 A. 512. Okay. Sorry.

24 Q. I've got my magnifying glasses on so I can see  
25 it.

1 A. Okay.

2 Q. And what was the average length of stay for  
3 the grant patients for that month?

4 A. 4.27.

5 Q. That's 4.27 days?

6 A. Yes.

7 Q. So the average length of stay for the grant  
8 patients in August 2014 was roughly 4.3 days?

9 A. Yes.

10 Q. All right. And I wanted to understand the  
11 accounting processes. I think it's important for the  
12 record to show in the accounting processes at Mountain  
13 States what you all -- what the last line says is the  
14 total remaining at the end of the month, which is the  
15 charges apparently at 477 per day less the grant  
16 amount of 210,000, 211,000 roughly. If you subtract  
17 the grant amount from the total charges you come out  
18 with just under \$34,000; is that right?

19 A. Right.

20 Q. For these patients, for example, if you were  
21 admitted on August 31, 2014, and the grant, let's use  
22 the term exhausted, had been used up by then,  
23 presumably you sort of take them as they come, and  
24 when the new month starts if you're a patient in the  
25 hospital under this grant -- if you're a patient in

1 Woodridge admitted under this grant program would your  
2 reimbursement per day be covered -- if you came in on  
3 August 31st and you had 3.27 days left, would those  
4 3.27 days in September be covered by this grant?

5 A. If you came in on August 31st but you were  
6 still there September 1st, your length of stay would  
7 go under the September grant.

8 Q. How about the reimbursement?

9 A. I don't know the answer to that. I'm not  
10 sure. The reimbursement from the state to us?

11 Q. Yes.

12 A. It would go under the September billing; so it  
13 would go under the September grant.

14 Q. Well, in the event that, for example, you  
15 didn't use up the grant in September, the remaining  
16 days for that patient admitted on August 31, those  
17 days that occurred in September would be covered by  
18 the grant, reimbursed by the grant?

19 A. If we didn't -- say that one again.

20 Q. Well, what I'm trying -- what I'm trying to  
21 make the record show, and I would like to learn  
22 myself. I'll take Mr. Swearingen, for example. If he  
23 were admitted on August 31 under the grant, and the  
24 grant in this case presumably was used up, let's say  
25 used up by August 31, and he stayed 3.27 days in

1 September. All I am trying to say is would those  
2 3.27 days in September be considered by the state and  
3 Mountain States to be reimbursed at 477 or whatever  
4 per day?

5 A. Yes, because they would be September days.

6 Q. They would be September days. Thank you.  
7 That was my question.

8 A. Okay.

9 Q. I think in your deposition we discussed these  
10 things as well. Does it show -- and you can actually  
11 determine the counties of origin by looking at this  
12 document?

13 A. Yes.

14 Q. And you can do it by utilizing the data  
15 dictionary codes for the county; is that right?

16 A. Yes.

17 Q. I remember asking you at your deposition this,  
18 or questions like this, and I wanted to ask this  
19 again: If I were a resident of Washington County,  
20 Virginia, but I was down in Tennessee for the NASCAR  
21 event, which I understand is up around Bristol,  
22 Tennessee -- assume for purposes of this question that  
23 the racetrack is in Sullivan County. Although I am a  
24 resident of Virginia, I'm physically in Tennessee, and  
25 I have some psychiatric event that causes me to be

1 hospitalized and they bring me to Woodridge. Would I  
2 be covered under the grant?

3 A. If you meet the qualifications under the grant  
4 and you were evaluated in a Tennessee hospital --

5 Q. Yes.

6 A. -- then you would have been if you were in  
7 Tennessee at a race and you would have probably been  
8 taken to a Tennessee hospital then, yes, you would be  
9 eligible for the grant.

10 Q. And that's okay with the state?

11 A. That's okay with the state. That's something  
12 I'm sure they monitor to see how many out-of-state  
13 persons they have. That's what they told us, this is  
14 fine, they know. We would put that you're from  
15 Washington County, Virginia, and they do monitor that.  
16 They have reimbursed on those.

17 Q. And in a sense, you know what EMTALA and  
18 EMTALA laws mean by emergency services, it makes sense  
19 from the standpoint of an EMTALA analysis or  
20 application or whatever that you're in a particular  
21 state you may get covered in that state.

22 THE COURT: You need to say yes or no.

23 THE WITNESS: Yes, sir.

24 MR. WEST: Your Honor, I would like to  
25 make this the next exhibit. It bears the Deposition

1 Exhibit Number 66; so I believe it would be Exhibit  
2 Number 66.

3 THE COURT: Exhibit 66 will be marked for  
4 inpatient psychiatric services data dictionary. Then  
5 the last two pages referred to is a monthly report for  
6 August 2014.

7 (Marked Exhibit No. 66.)

8 BY MR. WEST:

9 Q. Ms. Bailey, I'm going to show you another  
10 exhibit from your deposition. It's Exhibit 67. And  
11 ask if you can identify this as well.

12 A. This is another portion of a hospital report  
13 that goes to the Tennessee Department of Mental  
14 Health.

15 Q. And, again, if you'll look at -- I do  
16 acknowledge that the print is a little bit bigger on  
17 this one. It appears the first date of admission  
18 shown on page 1 is June 25, 2014, and the last date of  
19 admission shown is July 31, 2014. So this would  
20 essentially be a report similar to the one previously  
21 introduced but for the month of July 2014?

22 A. Yes.

23 Q. And, again, the same data is shown on the  
24 final page of this report beneath the chart in terms  
25 of length of stay, amount used, and that type of

1 thing?

2 A. Yes.

3 Q. And so in July the length of stay would have  
4 been 4.26? The average length of stay for a grant  
5 patient would have been 4.26 days?

6 A. Yes.

7 MR. WEST: Your Honor, I would like to  
8 make this the next exhibit if I may. It's Exhibit 67  
9 to the Bailey deposition.

10 THE COURT: 67 will be marked as a  
11 hospital report. It has a June and July date, I  
12 believe, listed on it.

13 (Marked Exhibit No. 67.)

14 BY MR. WEST:

15 Q. Ms. Bailey, listening to you testify today, I  
16 believe you indicated that it's your belief that  
17 Woodridge Psychiatric Hospital is meeting the mental  
18 health needs of the community?

19 A. Yes, sir.

20 Q. And that conclusion, is that different from  
21 what your conclusion might have been in say 2008 or  
22 2009?

23 A. I'm not exactly sure what you're asking.

24 Q. Well, I understood your comment in response to  
25 Mr. Swearingen's question to indicate that you believe

1 that all these things that Woodridge has done through  
2 this process that you described starting in late 2013  
3 or early 2014 increased the patient throughput, let's  
4 say, or increased the patient flow at Woodridge?

5 A. Yes.

6 Q. And that means that, if that's the case, the  
7 patient flow during the times before that wasn't as  
8 high; is that correct?

9 A. Before 2014?

10 Q. Yes.

11 A. But not -- I'm questioning -- what I don't  
12 understand is the 2008, 2009. I don't know how to  
13 answer your question.

14 Q. I'll back up. Ever since early 2014 when  
15 y'all went through all these processes, and you  
16 described them in your deposition as well, patient  
17 volumes at Woodridge have increased significantly; is  
18 that correct?

19 A. Yes.

20 Q. And, for example, you said that the average  
21 length of stay -- not the average length of stay, but  
22 the occupancy at Woodridge in July 2015 was -- well,  
23 you did say average daily census was 72; is that  
24 correct?

25 A. Yes.

1 Q. And that's just for July?

2 A. No, that was for the year.

3 Q. Which year?

4 A. That was the last fiscal year. For July the  
5 average daily census was 74 thus far.

6 Q. And so I used my calculator when you said that  
7 and I did the math. It appears, according to my  
8 calculator, to be an 85.7 percent occupancy rate for  
9 that year; is that correct?

10 A. If you say so. I estimated 85 percent.

11 Q. Well, you were pretty close. So at 74 in July  
12 would actually be a higher occupancy rate than that  
13 average?

14 A. Yes.

15 Q. So I'll get my calculator. My calculator  
16 calculates that comes out to 88 percent occupancy for  
17 July of this year; is that correct?

18 A. Okay. Yes.

19 Q. Certainly Mr. Swearingen can redirect if I've  
20 miscalculated.

21 MR. SWEARINGEN: I don't have a  
22 calculator like that though.

23 MR. CHRISTOFFERSEN: It's always dicey  
24 when lawyers try and do that.

25 MR. WEST: It's your extreme youth, I can

1 assure you.

2 BY MR. WEST:

3 Q. So, in other words, in terms of comparing the  
4 new fiscal year, at least so far in the new fiscal  
5 year utilization at Woodridge, is actually higher than  
6 it was on average for the full year of FY 2015; is  
7 that correct?

8 A. Yes.

9 Q. So there's been this increase over the last  
10 two years, and I think there's documents in the record  
11 that show, and I will ask you, the utilization at  
12 Woodridge wasn't nearly that high in 2012 or '13; was  
13 it?

14 A. No, it wasn't.

15 Q. And so you feel that Woodridge is meeting the  
16 needs of the community now. But was it not meeting  
17 the needs of the community when the utilization was  
18 much lower?

19 A. I think there have been an increase in  
20 referrals, an increase in inquiries. We also run a  
21 warm line, a phone line. We have more and more phone  
22 calls asking for information. I don't think that we  
23 were as -- I don't think we were doing all that we  
24 could to meet the needs of the population in 2013.  
25 That's one of the things that I was trying to make

1 reference to when I talked about the improvements in  
2 early 2014, because we weren't meeting all the needs  
3 of the emergency rooms and getting people through  
4 quickly.

5 Q. All right. And this CON application was  
6 actually filed in December of 2013; is that correct?

7 A. I believe that was.

8 Q. I believe also in this quality or flow through  
9 improvement process or whatever you described in late  
10 2013, was it December 2013 or January 2014 that all  
11 that was done?

12 A. It was January.

13 Q. In your deposition, in the documents that have  
14 been produced in this matter, I think a complaint was  
15 lodged in one of these flow documents where y'all were  
16 recording comments about the problems that Mountain  
17 States wasn't doing enough to publicize Woodridge; do  
18 you remember that?

19 A. I don't remember that statement.

20 Q. But you're saying that now Mountain States,  
21 you all at Woodridge or Mountain States, are doing  
22 more in terms of a phone line, for example, and doing  
23 a better job of communicating with the ERs; is that  
24 also true?

25 A. We're doing a better job of communicating with

1 the ERs. There's one really important thing that  
2 happened that we mentioned in the deposition that we  
3 haven't mentioned here. We changed leadership in  
4 December of 2013, and that made a tremendous impact on  
5 Woodridge. Our new leader, Dr. Dru Malcolm, had many  
6 years of experience in emergency rooms; so she saw the  
7 psychiatric issues from a different side. Our  
8 previous leader was not as assertive toward getting  
9 patients into the hospital and getting them in as  
10 quickly, and the patient flow. The new leadership  
11 made that a priority, thus the rapid improvement  
12 event, thus the improvement in taking care of the  
13 patients.

14 Q. And you referred -- I think it's Dr. Dru  
15 Malcolm?

16 A. Yes.

17 Q. And she's the Chief Nursing Officer at Johnson  
18 City Medical?

19 A. She's the Chief Nursing Officer for Woodridge  
20 located at Johnson City Medical Center also.

21 Q. And so she is actually sort of on the clinical  
22 side of things then --

23 A. Yes.

24 Q. -- as a nurse?

25 A. Yes, as a nurse.

1 Q. All right. And your prior administrator whose  
2 place she took, was he a clinician?

3 A. He was also a nurse. He's a Master's level  
4 nurse.

5 Q. I have to ask you this question: Why was he  
6 not focused on getting as many patients as possible  
7 into Woodridge?

8 A. I couldn't answer that question.

9 Q. Do you recall there being any time when  
10 Woodridge was instructed to limit its admissions to  
11 kind of hold down costs and so forth?

12 A. To hold down costs?

13 Q. Or hold down anything?

14 A. No.

15 Q. All right. So then the purpose of Woodridge  
16 all along then under whatever administration it had  
17 would have been to seek to admit as many people as  
18 needed its services; is that correct?

19 A. Yes.

20 Q. And despite that, the utilization has ramped  
21 up significantly even since 2013; is that correct?

22 A. Yes.

23 Q. And the grant covered 2013?

24 A. Yes.

25 Q. The Mental Health & Substance Abuse Services

1 grant that is Exhibit 53?

2 A. Yes.

3 Q. You referenced doing rounds yourself. I guess  
4 that's the first thing you do in the morning? Is that  
5 when you come in?

6 A. One of the first, yes.

7 Q. And what time of day is that?

8 A. 7:00 o'clock in the morning.

9 Q. You're keeping lawyers' hours. Before I get  
10 to some other exhibits, I wanted to ask you, and I  
11 think you've testified about it to some extent here,  
12 the term "Respond," is that the name for an  
13 organization or just a group within an organization?

14 A. That's the name for the crisis team. A group  
15 located within Woodridge Hospital.

16 Q. All right. And are they part of -- are they  
17 employees of Mountain States?

18 A. They are employees of Mountain States.

19 Q. All right. But they're separate from the  
20 community mental health center?

21 A. Yes. They're Mountain States' version of a  
22 crisis center.

23 Q. All right. So if Woodridge is meeting the  
24 needs of the community as you believe, what is your  
25 view of the need for any additional CSUs, crisis

1 stabilization units?

2 A. Well, crisis stabilization units meet a  
3 different need and actually they -- the crisis  
4 stabilization unit that we have for adults is very  
5 crucial to the mental health services in upper East  
6 Tennessee. Patients who don't need to be in the  
7 hospital but yet are still going through a crisis can  
8 be treated at a crisis stabilization unit. They can  
9 stay there for up to 72 hours. If for some reason  
10 that doesn't work and they continue to be or become in  
11 more of a crisis, they could then be referred into the  
12 hospital. The crisis stabilization unit can also be  
13 used on the back end. If you have a patient who is  
14 finished with their treatment, they really don't need  
15 that intensive level of inpatient hospitalization but  
16 they're not quite ready to face going home, they could  
17 go to the crisis stabilization unit for a day or two  
18 and get just a little bit more treatment in skills in  
19 dealing with going back to their living arrangement.

20 Q. So does Woodridge do that? You used the  
21 existing adult doesn't use that -- well, on the back  
22 end when the patient exits the hospital, Woodridge  
23 then refers them occasionally to the adult CSU that  
24 exists in Johnson City?

25 A. We have, yes.

1 Q. And how long has that CSU been operational?

2 A. I think it opened up in 2009.

3 Q. All right. And what has been the utilization  
4 at Woodridge? What has the been the -- if you  
5 compared the utilization at Woodridge Psychiatric  
6 Hospital in 2009 with the utilization at Woodridge  
7 Psychiatric Hospital in fiscal year 2015, how would  
8 they compare?

9 A. I would have to see numbers to be able to  
10 compare that.

11 Q. Is it higher now than it was then in your --

12 A. I believe it is.

13 Q. It was higher in 2015 than it was in 2014; is  
14 that correct?

15 A. Yes.

16 Q. And it was higher in 2014 than it was in 2013?

17 A. Yes.

18 Q. All right. So the presence of this adult CSU  
19 in Johnson City in Washington County has not retarded  
20 the growth in Woodridge Psychiatric Hospital's  
21 utilization, has it?

22 A. No.

23 Q. And in reality or at least in -- as you just  
24 testified, it appears to me from what you said that  
25 CSUs in that context actually serve a different

1 function than the psychiatric hospital?

2 A. Somewhat. If you did not have CSUs, many of  
3 those people who are going to the CSUs would require  
4 hospitalization because something less than the CSU  
5 would not be sufficient; so, therefore, there would be  
6 more people needing services inpatient going to  
7 Woodridge, one of these other hospitals in the area,  
8 Peninsula, Moccasin Bend. So the CSUs do prevent  
9 hospitalizations.

10 Q. And so the CSU, despite their function in  
11 preventing hospitalization though, hospitalization has  
12 been rapidly increasing at Woodridge; is that correct?

13 A. Yes.

14 Q. Have you had any discussion with anyone or  
15 heard anything about opening an adolescent CSU in  
16 Washington County?

17 A. Yes.

18 Q. And what has that discussion been?

19 A. I've been involved with some of the planning  
20 sessions for the adolescent CSU.

21 Q. And what is the status of that project now?

22 A. Right now we're waiting on a -- they're  
23 working out the lease arrangements between Mountain  
24 States and Frontier Health. And then there will be a  
25 letter of intent. We're moving forward with the joint

1 venture of working together with Frontier Health and  
2 really excited about doing that to open up a CSU  
3 hopefully in winter, early spring 2016.

4 Q. How many beds will the CSU have?

5 A. They'll probably take 10 to 12 adolescents.

6 Q. All right. And where will it be located?

7 A. It will be located in Gray, Tennessee, which  
8 is near Sullivan County but in Washington County.

9 Q. And that's actually the headquarters of  
10 Frontier, isn't it? Located in Gray?

11 A. The headquarters is located in Gray.

12 Q. And the building that is being used, is that  
13 one that Mountain States already owns?

14 A. It is a Mountain States building.

15 Q. So it's a Mountain States medical office  
16 building currently?

17 A. It has been used as a medical office.

18 Q. So Mountain States essentially will be the  
19 landlord; is that correct?

20 A. Uh-huh, yes.

21 Q. And it won't have any other involvement in the  
22 CSU other than the landlord?

23 A. Correct. The community mental health center  
24 Frontier will supervise the clinical arrangements.  
25 They'll provide the clinicians and the treatment.

1 Q. All right. Would you describe the  
2 development, what has happened so far in the meetings  
3 you've been in or what meetings you've been in  
4 concerning the CSU, the adolescent CSU?

5 A. Just working towards what is needed, what we  
6 want, Frontier working about the licensure.

7 Q. Well, currently CSU regs do not permit  
8 adolescent CSUs, do they? They only provide for adult  
9 CSUs, correct?

10 A. There are no CSU -- adolescent CSUs in the  
11 State of Tennessee currently.

12 Q. Right. Because the State of Tennessee license  
13 requirements under the Mental Health Department for  
14 CSUs limit them to adults only? People over 18?

15 A. Because that's all we've had thus far in the  
16 State of Tennessee.

17 Q. But it is a true statement though? Currently  
18 the regulations say CSUs only serve people over 18?

19 A. Yes.

20 Q. And when did these meetings that you have  
21 attended so far, when did they occur?

22 A. They have occurred over the last several  
23 months. We have been working on this for several  
24 months now.

25 Q. Had any occurred before I took your

1 deposition?

2 A. Yes.

3 Q. All right. And who, other than yourself, is  
4 involved in that? Can you name the individuals who  
5 have been at the meetings?

6 A. I can from the Frontier Health side.  
7 Dr. Randy Jesse, Dr. Terry Kidd, Christie Hammonds,  
8 who is one of the vice presidents. From the Mountain  
9 States side, Marvin Eichorn, Kasey McDevitt, I'm sure  
10 I'm going to miss some people. Dr. Dru Malcolm, Lindy  
11 Smith, our CEO.

12 Q. If I may interrupt. Ms. Smith was actually  
13 the CEO at Johnson City Medical Center?

14 A. She's actually the CEO at Franklin Woods  
15 Hospital and Woodridge.

16 Q. All right. I'm sorry, I interrupted you.

17 A. And Joshua McFall. I'm sure I've missed some.

18 Q. Have there been any individuals from the State  
19 Mental Health Department present at the meetings?

20 A. No.

21 Q. And what is the reimbursement, as you  
22 understand it, proposed per day?

23 A. I think you would have to have somebody on the  
24 Frontier Health side to ask that question.

25 Q. You have not seen it?

1 A. They're making those arrangements. Frontier  
2 Health is making the arrangements.

3 Q. That number, has that number been disclosed to  
4 you at all?

5 A. No.

6 Q. What is the level of staffing that you  
7 understand the adolescent CSU will have to have?

8 A. Again, you'll have to ask somebody on the  
9 Frontier Health side.

10 Q. All right. In response to Mr. Swearingen's  
11 questions you were describing, you, in fact, described  
12 kind of the development process for the state grant.  
13 You were directly involved in that; is that correct?

14 A. I wasn't directly involved with the state. I  
15 was involved with my administrator at the time. We  
16 worked together on, you know, just what could we do,  
17 what number of beds we could provide the state, could  
18 we accommodate the ten extra patients they were asking  
19 us to accommodate.

20 Q. And when you say ten extra patients, I mean  
21 ten extra patients per day. Is that what y'all were  
22 anticipating?

23 A. Yes.

24 Q. And, in fact, you all engaged in a fairly  
25 detailed analysis of what the cost benefit effect

1 would be of having that additional patient flow; is  
2 that correct?

3 A. I'm sure our financial people did. I didn't.

4 Q. All right. Mr. Swearingen asked you a number  
5 of questions about Indian Path Pavilion back in the  
6 day. I call it Indian Path Pavilion, I mean the  
7 psychiatric component of Indian Path Medical Center.

8 A. Yes.

9 Q. I think once they were independent, but then  
10 they merged back together as many hospitals do. But  
11 it was in Kingsport; is that correct?

12 A. Yes.

13 Q. In 2005, who owned Indian Path Pavilion?

14 A. Indian Path Medical Center, which is Mountain  
15 States Health Alliance.

16 Q. Because Mountain States had acquired what had  
17 been ACA hospitals as a group sometime right around  
18 the year 2000, or maybe a year before; is that  
19 correct?

20 A. I vaguely remember some of that history.

21 Q. The point I'm trying to make is in the 2005  
22 time, the year 2005 when Mountain States acquired  
23 Woodridge, Mountain States already owned Indian Path  
24 Mental Center and Indian Path Pavilion?

25 A. Yes.

1 Q. So your comments about the type of care that  
2 Indian Path Pavilion provided, you were describing a  
3 time period in which it was operated by Mountain  
4 States?

5 A. Yes.

6 Q. And I wanted to go back through this because I  
7 was taking notes while you were testifying in response  
8 to Mr. Swearingen's questions. I believe you said  
9 that the utilization at Indian Path Pavilion that you  
10 saw on the exhibit that was disclosed to you, whether  
11 it was roughly close to 12 to 1,300, you thought it  
12 was actually closer to 2,500 for that year?

13 MR. SWEARINGEN: Just for clarification,  
14 I think you mean Woodridge?

15 MR. WEST: I'm sorry. Woodridge.

16 THE WITNESS: Yes.

17 BY MR. WEST:

18 Q. If I could, let me examine the exhibit, Your  
19 Honor. I need to -- if I may take a moment. In  
20 Exhibit 246, do you have it in front of you?

21 A. Yes.

22 Q. Mr. Swearingen was correct. I did mean  
23 Woodridge. In 2005, and I just want to make sure I  
24 understand this, you believe that, which was the year  
25 that Mountain States acquired Woodridge, the number

1 that's given for the calendar year 2005 utilization at  
2 Woodridge for that year you believe is essentially  
3 twice as large as that or 2,500 instead 1,295?

4 A. I would guess. That is a guess but, yes. My  
5 thought is this is only a portion of that year since  
6 Woodridge was only owned by Mountain States for a  
7 portion of that year.

8 Q. I see. Okay. In 2005 you were working at  
9 Woodridge; is that correct?

10 A. Yes.

11 Q. Did Woodridge provide chemical dependency-type  
12 services back in that time period? 2005 and before?

13 A. Yes.

14 Q. So that's a separate diagnosis than just  
15 psychiatry alone; is that correct?

16 A. Yes, it is.

17 Q. All right. While you were testifying in  
18 response to Mr. Swearingen's questions, you referenced  
19 the out-patient programs that Woodridge provides?

20 A. Yes.

21 Q. Would you walk through them again in terms of  
22 what they are and what kind of care they provide?

23 A. We have intensive out-patient program, which  
24 is a program where patients meet three days a week for  
25 three hours a day. We have two of those groups. They

1 generally stay in that program from four to six weeks.  
2 And that can be used as a step-down program from the  
3 hospital or it can be used as a program prior to  
4 coming to the hospital for someone who doesn't quite  
5 meet the intensity level of needing hospitalization.  
6 We have that. We have some partial hospitalization,  
7 and that's where a person comes and stays for at least  
8 six hours a day and goes through the regular  
9 programming within the hospital but then goes home at  
10 night generally.

11 Q. And are both of those programs offered on  
12 campus at Woodridge?

13 A. Yes.

14 Q. And they're not offered anywhere else than the  
15 campus at Woodridge?

16 A. Our programs are offered on campus. There are  
17 other programs in the community that other services  
18 offer, but our programs are offered on campus.

19 Q. And in your deposition I asked you about  
20 another -- the reduction in the out-patient revenues  
21 for Woodridge for a recent year, and I believe you  
22 indicated that there had been a time prior to 2014  
23 when Woodridge also had an all campus out-patient?

24 A. Our intensive out-patient, and an out-patient  
25 service, medical management, and out-patient therapy,

1 was offered off campus.

2 Q. Was that in Johnson City?

3 A. That was in Johnson City.

4 Q. And that office has been closed; is that  
5 correct?

6 A. That office has been closed, and the intensive  
7 out-patient then was moved to Woodridge.

8 Q. And that was approximately April of 2014 when  
9 that happened?

10 A. Yes.

11 Q. So in reality to some extent, at least to that  
12 extent, Woodridge has reduced its own out-patient  
13 services in terms of the geographic dispersal event?

14 A. Woodridge reduced that out-patient clinic, but  
15 that out-patient clinic still is intact because the  
16 physician essentially moved it herself. She took the  
17 practice, the patients who wanted to go with her, and  
18 opened another practice. So the services are still  
19 being provided but not under Woodridge or Mountain  
20 States' management.

21 Q. Ms. Bailey, when you have testified about the  
22 history of the development of this grant from Mental  
23 Health & Substance Abuse Services --

24 A. Yes.

25 Q. -- so when the Department of Mental Health &

1 Substance Abuse Services had discussions with Mountain  
2 States about developing this grant program because  
3 they were closing down Lake Shore in Knoxville, did  
4 they ask Mountain States to treat these patients for  
5 free?

6 A. Not as I recall, no.

7 Q. In other words, they came to Mountain States  
8 and said, we are willing to pay you 2.526 million in  
9 2014, but roughly 2.5 million in fiscal 2014, to take  
10 care of the patients described in the grant?

11 A. That was the agreed upon amount.

12 Q. And the source of all that from the state's  
13 side, at least as far as they manifested it to you,  
14 was that they were in the process of closing down Lake  
15 Shore, they needed some other place for patients to  
16 go; is that correct?

17 A. Yes.

18 Q. And they contracted with Mountain States up in  
19 the Tri-Cities area, and they contracted with  
20 Peninsula Hospital down around Knoxville --

21 A. Yes, near Knoxville in Louisville.

22 Q. So it's not in Knox County I don't think; is  
23 it?

24 A. No, it's in --

25 Q. Blount County?

1 A. -- Blount County.

2 Q. And then also a smaller hospital I believe in  
3 Oak Ridge; is that correct?

4 A. Ridgeview in Oak Ridge.

5 Q. And that's relatively small?

6 A. Yes.

7 MR. WEST: Your Honor, I have a series of  
8 questions to ask Ms. Bailey about the patient flow  
9 sheets and some of the other exhibits that were  
10 introduced. I just wanted to take a moment, if I can,  
11 to get that organized.

12 THE COURT: What's your estimate of how  
13 much longer you have for Ms. Bailey?

14 MR. WEST: Fifteen to 20 minutes.

15 THE COURT: Why don't we take a short  
16 break and come back and finish up.

17 (Recess observed.)

18 BY MR. WEST:

19 Q. We're back on the record, Ms. Bailey. I took  
20 the liberty of setting some of the exhibits in front  
21 of you there. I was going to ask you about them. Can  
22 you see if there is a large exhibit in front of you?  
23 Exhibit 46. There's a document tag at the lower  
24 right.

25 A. Yes, sir.

1 Q. Is that it?

2 A. Yes.

3 Q. All right. Will you look at that? Just use  
4 the first page, and I'd like to ask you some questions  
5 about it. Is this one of the flow sheets you talked  
6 about?

7 A. This is a patient flow sheet, a worksheet,  
8 yes.

9 Q. Okay. Let me ask you a series of questions:  
10 Does it indicate Woodridge is literally named for  
11 trees, their buildings are; is that correct?

12 A. Our units are named after trees.

13 Q. Okay. So you have five units; is that  
14 correct?

15 A. Correct.

16 Q. And they're Cedar, Laurel, Poplar, Spruce, and  
17 Willow; is that right?

18 A. Yes.

19 Q. On this flow sheet, which is part of  
20 Exhibit 46, which is this same document 1441, it  
21 appears that for each tree building listed, for each  
22 building or board listed, there's a number next to it.  
23 Is it the number of beds?

24 A. That's the number of available beds on that  
25 unit.

1 Q. All right. And are these numbers accurate?

2 A. Cedar actually has the ability to take 16  
3 people, but the working number is 14.

4 Q. Why is that?

5 A. That's because we're a very old building, very  
6 limited in space. It was built in 1985. And one of  
7 the patient rooms is actually being used as a  
8 physician's office and the treatment team room and the  
9 office where the physician meets with the patient.

10 Q. And is that still true today?

11 A. That is true today.

12 Q. So if Woodridge had 83 patients on a  
13 particular day, it would be full then?

14 A. Well, we have the ability to use that room if  
15 we need to. We actually have beds for that room, but  
16 we generally choose to use it for the doctor's office  
17 because they need a space to meet the patients in and  
18 the treatment teams.

19 Q. So on this particular day, those two beds  
20 aren't listed as available beds, the two that would  
21 normally be in the doctor's office room?

22 A. Yeah, they're not listed on here because we  
23 have 14 listed here.

24 Q. But if you did the calculations for  
25 utilization based on those beds, you really would be

1 looking at an 82-bed hospital instead of 84, wouldn't  
2 you?

3 A. But we're licensed for 84.

4 Q. What happens to the physician's office if that  
5 room is needed?

6 A. Then we go through a succession of movements.  
7 We have to move the discharge planner out of her  
8 office and the physician moves in her office and then  
9 she doesn't really have an office temporarily unless  
10 she shares one with somebody else; so it gets kind of  
11 complicated.

12 Q. But they don't go into another patient, I  
13 mean, if they're so full that they need that room, you  
14 don't take up another patient room in that physician  
15 office, do you? If they move out the one that has  
16 sort of been used as a physician's office?

17 A. We have used it for a physician office mostly  
18 lately.

19 Q. And would you describe, for the record, the  
20 sort of functional purposes or what type of diagnosis  
21 or what type of patients use each one of these  
22 buildings or wards or whatever?

23 A. Units.

24 Q. Units. Thank you.

25 A. Cedar is the most acute unit. That's the unit

1 where most of the patients on that unit are committed,  
2 brought in against their will often by sheriff's  
3 department or by Mountain States own transport. Those  
4 are patients that do not want to be there. They may  
5 be schizophrenic, off their medications, extremely  
6 depressed, truly want to kill themselves, may have had  
7 a serious gesture, such as a hanging, a shooting, a  
8 stabbing; so those are your sickest most serious  
9 patients. Generally the patients that you're talking  
10 about coming from Lake Shore would be a Cedar kind of  
11 patient.

12           Laurel patients, that's a step-down unit, a  
13 16-bed unit, and it could be either used as a  
14 step-down from Cedar as a Cedar patient progresses and  
15 starts getting a little bit better, or it could be a  
16 direct admit to Laurel. Laurel is more for your  
17 chronic, long-term mentally ill patient who maybe they  
18 go to the mental health center but their medications  
19 just aren't working anymore. So they're in a  
20 situational crisis where they need to be stabilized.

21           Poplar is mostly detox. There are some high  
22 functioning psychiatric folks on Poplar, but most of  
23 Poplar is a detox unit and it's an adult 26-bed unit.  
24 You can be admitted directly to any of these units or  
25 you could move from one unit to another. If you were

1 on Poplar and you became violent and explosive, the  
2 doctors would probably move you to a higher level of  
3 care.

4 Spruce is the geriatric unit, 14-bed geriatric  
5 unit generally thought of for ages 55 and above, or it  
6 could be for persons maybe a little bit younger if  
7 they had some inability to do their activities of  
8 daily living and maybe needed some help with those.

9 And then Willow is the child and adolescent  
10 unit, 12-bed unit for ages 16 to 18.

11 Q. For this first page of Exhibit 46, I have some  
12 questions about some of the notes. Like in the Laurel  
13 unit, the top line of the Laurel unit it says 1C-bed.  
14 What does that mean?

15 A. That's just our own code for -- a C-bed is a  
16 bed that's not really there. This is, again, early in  
17 the morning. It's a worksheet. It's not an official  
18 census. A C-bed, it looks to me from looking at this,  
19 it looks like we have no blocked rooms but we have a  
20 male bed available. It appears that we had a female  
21 who needed to be on this unit as decided by the  
22 doctor; so we made arrangements for her to come. It  
23 doesn't even mean that she's here yet. Mostly likely  
24 she's not here. You would have to look at the real  
25 census to see.

1           Like I said, this is a worksheet, this let's  
2 us start flowing; so we've already made an arrangement  
3 for a female bed to come here knowing that it is  
4 probably going to take her two or three hours,  
5 depending on where she is to get here from a hospital  
6 to our C-bed, by which time we will have a discharge,  
7 which is not reflected on here, the number of  
8 discharges that we know we're going to have that day.

9           That's why I say it's a working copy. It's  
10 not an official census that goes anywhere. It's just  
11 for us to keep up with who's where and where we all  
12 are at the same time.

13           The private rooms, there's a private room on  
14 Poplar. Most likely that's because of some infectious  
15 issue. A person who might have had MRSA who couldn't  
16 have a roommate or a person -- since it's on Poplar I  
17 would think it would be an infectious issue. Same  
18 thing on Willow. That could be an infectious issue,  
19 lice, MRSA. On Poplar it could be -- on Willow with  
20 the adolescents it could be a child who maybe there  
21 was some sort of sexual perpetration issue or  
22 something and couldn't have a roommate or it could  
23 even be an age-related issue. You might have one  
24 really young child and they needed a private room,  
25 although that's probably not the issue since there

1 were only five adolescents at the time.

2 Q. Again, what is the age range served by Willow?

3 A. Ages 6 to age 18.

4 Q. Six to 18?

5 A. Yes.

6 Q. And I know -- I understand what your comments  
7 are about official census and so forth, but is this  
8 document an accurate reflection of people in the beds  
9 as of 8:30 A.M. on August 1, 2014?

10 A. I can't say that it's an accurate reflection  
11 of who is in the beds. I can say it's an accurate  
12 reflection of how your day is going and who you're  
13 planning to be in the beds. I would have to look at  
14 the census at that particular moment to see who is in  
15 the bed.

16 Q. And you had described earlier, I understand it  
17 to be a daily planning process where you use a  
18 whiteboard?

19 A. Yes.

20 Q. Does it resemble this in any way?

21 A. A little bit. The whiteboard actually has  
22 sort of codes for each patient, and it tells you what  
23 unit they're on, who their doctors are, if they're  
24 going to be discharged, if they're in a private room.  
25 So it's actually like looking at a census board, but

1 it also is a planning board, because you're planning  
2 for who is going to be transferred out from one unit  
3 to another or who is going to be discharged. You're  
4 planning for who is going to be admitted and then  
5 they'll move in. Everything is color coded. You're  
6 also planning for who is leaving the hospital, and you  
7 need to see them because their insurance company wants  
8 you to do a bridge appointment, which is just a simple  
9 appointment with the person as they leave the hospital  
10 to go over their out-patient plan, because that helps  
11 recidivism if you can go over that one more time  
12 before they go out the front door; so those things are  
13 on the board. The board also has other things, like  
14 who is on-call for the day and how to reach anybody  
15 you need to reach.

16 Q. So it has -- I'm sorry.

17 A. Yes, it has extensive, lots of information on  
18 the board. But it has -- you know, some of this  
19 information is similar.

20 Q. And what is the use that's made of the patient  
21 flow sheet?

22 A. It's just so that everybody that's working in  
23 Respond and we can share it with our physicians know  
24 kind of what you're looking at. Like if we hand a  
25 physician a flow sheet that says we've got three

1 people waiting, and they all need Cedar, then that  
2 doctor on Cedar is going to go, okay, I need to see my  
3 discharge patients first so I can make room. It's  
4 simply a planning thing.

5 In Respond we stagger the times that we come  
6 in. We don't come in at eight and leave at five. We  
7 come in at seven, nine, eleven, one, you know, so each  
8 person as they come in can kind of see where we are  
9 and how we're going with our flow.

10 Q. I don't want to belabor the point too much,  
11 but I would ask you to look farther back in that  
12 document. The easier way to find the page number is  
13 this page 1509 at the lower right for September 21,  
14 2014.

15 A. Okay.

16 Q. Have you located that?

17 A. I've got it.

18 Q. All right. Again, this one was actually at  
19 7:00 A.M.; is that correct?

20 A. Yes.

21 Q. It's for September 21, 2014?

22 A. Yes.

23 Q. And as of 7:00 A.M., September 21, 2014, there  
24 is a census reported on the flow sheet of 80; is that  
25 correct?

1 A. Yes.

2 Q. And it looks as though from the flow sheet by  
3 itself there are no beds available in Cedar, there are  
4 no beds available in Laurel, there are no beds  
5 available in Spruce, and there are no beds available  
6 in Willow. Is that what this chart says?

7 A. Right.

8 Q. Willow has one blocked room it says; is that  
9 correct?

10 A. Willow has one blocked room? Yes, yes, I see  
11 it now. I'm sorry.

12 Q. And Willow actually has a unit that has four  
13 beds in it; a room that has four beds in it?

14 A. They have one room that has four beds.

15 Q. And is that room used for a particular type of  
16 diagnosis or is it just built that way?

17 A. No, it's just built that way.

18 Q. Okay. The question I really wanted to ask you  
19 about this page is if you look down at the bottom half  
20 of the page with the census number at the top, it  
21 looks like there are about eight patients waiting?

22 A. Yes.

23 Q. And this gives you information about where the  
24 patients are, right?

25 A. Yes.

1 Q. So there's a Hawkins Emergency Department. I  
2 assume that Hawkins ED means the emergency department  
3 in the hospital in Hawkins County?

4 A. Yes. Hawkins County Emergency Department.

5 Q. And HVH ED, what is that?

6 A. Holston Valley Hospital in Kingsport.

7 Q. So there are three people at the Holston  
8 Valley Emergency Department in Kingsport; is that  
9 correct?

10 A. Yes.

11 Q. I'm trying to speed up the process here. I  
12 want to walk through this. It appears that the  
13 waiting list data gives you the patient name, which we  
14 don't want to see and can't see, the location of the  
15 patient, the sex of the patient, the age of the  
16 patient and then there's a column called LOS since  
17 consult. What does that mean?

18 A. Well, remember, this is a worksheet. This  
19 kind of came out of a rapid improvement event. It's  
20 length of stay -- it could be actual length of stay in  
21 the hospital from the time the person arrived,  
22 depending on what the referral source told us. It  
23 could be the length of stay from the time the patient  
24 was referred to us, say, by Frontier Health; so that  
25 consult, that's what they're referring to, or the

1 consult that was done by Respond if they saw the  
2 patient; so it's a little bit misleading. But, again,  
3 it's a worksheet; so we haven't cleaned it up or  
4 refined it.

5 Q. And the number there like ten plus, does that  
6 mean ten hours?

7 A. That means ten hours.

8 Q. So the second patient listed here, it's been  
9 ten plus hours since they had a consult with Respond?

10 A. And in that case it could have even been a  
11 psychiatrist that they had a consult with, because  
12 that's a floor patient. So that tells me they might  
13 have seen a psychiatrist.

14 Q. I see. How about the emergency departments?  
15 Are the psychiatrists generally --

16 A. Generally the psychiatrists don't do the first  
17 consults in the emergency departments. That would be  
18 Respond or a crisis person.

19 Q. If you look at the next page, page 1510. On  
20 the patient flow sheet on this date, 9/22/2014, was  
21 done at 7:30 A.M.?

22 A. Yes.

23 Q. And it showed 81 patients as the census; is  
24 that correct?

25 A. Yes.

1 Q. And on this flow sheet it shows zero beds  
2 available; is that true?

3 A. Yes.

4 Q. And the first entry on the waiting list  
5 appears to me -- I wanted to ask you if this is  
6 correct: You have one male patient waiting at Holston  
7 Valley Medical Center, which presumably would that be  
8 in the emergency department?

9 A. Probably.

10 Q. And he's 22 years old and has a length of stay  
11 since consult of two days?

12 A. Most likely because it's Holston Valley. It  
13 wouldn't have been Woodridge response seeing the  
14 patient. It would have been Frontier Health crisis  
15 seeing the patient. And most likely we told them, and  
16 he's showing up on your deferral report as a deferral,  
17 that we couldn't take the patient, we didn't have a  
18 bed or whatever. For whatever reason they've chosen  
19 to let him stay there until we did have a bed.

20 That's not an unusual thing to happen that we  
21 will say we don't have a bed available. And then  
22 they'll call us back the next day and say we still  
23 want him to come here or he still wants to come to  
24 Woodridge. We know he's been waiting, but keep him on  
25 the waiting list and get him in when you can. They're

1 treating him.

2 Q. So in that particular case, he would be at a  
3 hospital receiving some kind of treatment?

4 A. He would be at a hospital receiving some kind  
5 of care. He would be kept safe, he most likely would  
6 have a sitter. You know, we're guessing about all  
7 this because we don't know. But, yeah, that's kind of  
8 a typical scenario for somebody who might have waited  
9 a long time.

10 Q. So on this day if you had indicated that he  
11 was deferred, he would show up in your deferral count  
12 as a presumably Sullivan County since it's a Kingsport  
13 hospital?

14 A. Yes.

15 Q. And he's been deferred. He might ultimately  
16 get in, but he's been waiting two days so far?

17 A. It's possible. I mean, people get on the  
18 deferral list, but then they still come in the  
19 hospital. They get on the deferral list for medical  
20 reasons, and then when they clear they come in the  
21 hospital. They might be listed as a deferral because  
22 we don't have a bed and then when we get a bed they  
23 come in. So, yes, all of that is possible.

24 Q. All right. You can put that exhibit back  
25 together I guess.

1 MR. WEST: That's already been  
2 introduced, Your Honor, I believe. I believe it was  
3 introduced yesterday.

4 THE COURT: It appears that it was  
5 already marked as 46.

6 MR. WEST: 46. Yes. Thank you.

7 BY MR. WEST:

8 Q. Ms. Bailey, if you could pick up an even  
9 larger exhibit, it would be Number 238. I believe  
10 that is in front of you. Just look at the first page  
11 for the moment. Is the first page of this exhibit  
12 basically New Year's Day 2013?

13 A. Yes.

14 Q. All right. So it's a similar -- you can leaf  
15 through it. These documents in Exhibit 238 appear to  
16 be similar flow sheets but they cover time in 2015?

17 A. Yes.

18 Q. I wanted to ask you about a couple of days.  
19 If you would look way back in the back of that  
20 document to June, page 2071, at the lower right  
21 corner.

22 A. June 24th?

23 Q. Yes, ma'am. In 2015. Is it correct that this  
24 sheet, for whatever it's worth, appears to show that  
25 this flow sheet was filled out around -- or contained

1 data for 7:30 A.M. on June 24th, 2015?

2 A. Yes.

3 Q. All right. And at that time there was a  
4 census of 79 reported on the flow sheet?

5 A. Yes.

6 Q. And there are ten deferrals listed or ten  
7 people on the wait list?

8 A. Right.

9 Q. All right. And a number of these are at -- is  
10 it Holston Valley Medical Center, HVMC?

11 A. Yes, three.

12 Q. One of them is in the emergency department; is  
13 that correct?

14 A. Correct.

15 Q. And then there's also one patient from Hawkins  
16 County listed; is that correct?

17 A. Yes.

18 Q. And according to the bed availability line on  
19 this sheet, there are no beds available in Cedar, none  
20 in Laurel, and none in Spruce; is that correct?

21 A. At 7:30 in the morning, correct.

22 Q. And there is one available in Poplar, which is  
23 actually the biggest building with the most beds; is  
24 that correct?

25 A. Twenty-six beds.

1 Q. And one female bed available in Willow?

2 A. Yes.

3 Q. So it says 1F; that means one female?

4 A. Right.

5 Q. You can put that back together. I just wanted  
6 to ask you a few questions about it.

7 Ms. Bailey, in your experience over many years  
8 at Woodridge, what is the -- how do the seasons of the  
9 year line up in terms of need or demand for  
10 psychiatric hospital services? Which is the busiest  
11 season and which is the least busiest?

12 A. Other than the adolescents, it's not  
13 predictable. There have been years when December is  
14 very slow and January is very busy, and then there  
15 have been years when it's been the opposite. And the  
16 only thing that's predictable about adolescents -- and  
17 that hasn't proven true in the last two seasons --  
18 generally adolescent goes down in the summertime, the  
19 adolescent census falls in numbers. And we think it's  
20 because adolescents are in that structured school  
21 setting where people see what's going on and recognize  
22 problems. That's what we attribute it to. But quite  
23 generally, adolescents is down in the summer but  
24 hasn't been this summer or last summer.

25 Q. So it has stayed up at the school year level

1 or whatever?

2 A. It has stayed up at the school year level,  
3 yeah. But there's really not a lot of predictability.  
4 You have seasons and you have lulls. We can't  
5 identify it.

6 Q. Does Washington County go to the year-around  
7 public school year?

8 A. No, no. The only thing that changed is that  
9 Youth Village is no longer around and Frontier Health  
10 took over the adolescent TennCare referrals.

11 Q. When did that occur?

12 A. July 1st of 2014.

13 Q. So since that time, your adolescent flow has  
14 been staying at school levels during the summertime?

15 A. Yes.

16 Q. Over your long career at Woodridge and  
17 currently has there, in your experience, been a rise  
18 in the incidents of psychiatric care problems? Mental  
19 health care problems?

20 A. Yes.

21 Q. So there's more of it, it occurs at a higher  
22 rate now than when you began?

23 A. There's more of it. It occurs at a higher  
24 rate, but it's also -- and this is a piece of it, more  
25 easily identifiable. There are services available,

1 people know about them. I don't actually believe that  
2 there is the stigma attached that once was about  
3 receiving mental healthcare.

4 Q. All right. So then if people know about them,  
5 for example, if they're publicized or you have a  
6 call-in line or whatever, then the utilization in  
7 Woodridge's case has risen as a consequence?

8 A. Our utilization has risen.

9 Q. As a consequence of better publicity or better  
10 public knowledge?

11 A. Possibly, yes.

12 Q. I know you may feel like one sometimes.  
13 That's my own personal observation from being married  
14 to a psychologist. You have clinical training  
15 yourself?

16 A. I'm a social worker.

17 Q. Are you a clinical social worker?

18 A. No, I'm not clinical, I'm not licensed as a  
19 clinical social worker.

20 Q. That was my question, yes. All right. If you  
21 will look at Exhibit 240 in your -- this is just a  
22 single page, I believe. Exhibit 240 appears to say  
23 that it's a list of adult deferrals at Woodridge from  
24 January 2015 to May 2015 by the county of wherever  
25 those people are?

1 A. Yes.

2 Q. So Sullivan County is the one with the highest  
3 number?

4 A. Yes, it is.

5 Q. If you'll look also at Exhibit 241, which is  
6 also a single page, which I think is in front of you  
7 there. Exhibit 241 appears to list the reasons for  
8 deferrals?

9 A. Yes.

10 Q. And what is the total number of deferrals for  
11 adults for January 2015 to May 2015?

12 A. 194.

13 Q. And what reason for deferral causes the most  
14 deferrals?

15 A. Appropriate bed not available.

16 Q. And how many of those are there?

17 A. 126.

18 MR. WEST: Your Honor, may I consult with  
19 my co-counsel for just a minute?

20 THE COURT: Yes.

21 MR. WEST: Your Honor, I believe that's  
22 all the cross-examination I have for Ms. Bailey. I  
23 apologize to the Court and Ms. Bailey and counsel that  
24 I may have underestimated the amount of time.

25 THE COURT: Any redirect?

1 MR. SWEARINGEN: No, Your Honor.

2 THE COURT: Ms. Bailey, you can step  
3 down. Please don't discuss your testimony or any of  
4 the exhibits with anyone else.

5 All right. Counsel, based on our earlier  
6 discussion, I think that concludes the proof for  
7 today; is that correct?

8 MR. WEST: Yes, Your Honor.

9 THE COURT: And based on your earlier  
10 estimates, we still seem to be on schedule. Finish on  
11 Friday?

12 MR. SWEARINGEN: I think so. Tomorrow  
13 might be a little bit of a busier day, and then I  
14 think we'll plan on probably being done by lunchtime  
15 on Friday.

16 THE COURT: All right. We're adjourned  
17 until tomorrow.

18 (Proceedings were adjourned at 12:32 p.m.  
19 to be reconvened at 9:00 a.m. on July 30, 2015.)  
20  
21  
22  
23  
24  
25

BEFORE THE TENNESSEE  
HEALTH SERVICES AND DEVELOPMENT AGENCY  
Nashville, Tennessee

IN THE MATTER OF:	)	
	)	
SBH-KINGSPORT, LLC	)	
	)	
Applicant,	)	
	)	
vs.	)	No. 25.00-126908J
	)	
TENNESSEE HEALTH SERVICES	)	
AND DEVELOPMENT AGENCY	)	
	)	
Respondent,	)	
	)	
and	)	
	)	
MOUNTAIN STATES HEALTH	)	
ALLIANCE,	)	
	)	
Intervenor.	)	VOLUME 4 of 5

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TRANSCRIPT OF PROCEEDINGS

Taken before Administrative Law Judge Leonard Pogue

Commencing at 9:00 a.m.

July 30, 2015

**ORIGINAL**

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P R O C E E D I N G S

THE COURT: Good morning, everyone.

THE COURT: Good morning, Your Honor.

THE COURT: Are we ready to proceed to our next witness?

MR. SWEARINGEN: We are, Your Honor. Mountain States would call Dr. Randy Jessee.

RANDALL E. JESSEE, was called as a witness, and after having been first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. SWEARINGEN:

Q. Would you please state your full name.

A. Randall Edward Jessee.

Q. And, Dr. Jessee, could you give us a little information about your education, your background and who you are?

A. Sure. I went to undergraduate school at the University of Tennessee, graduated with a Bachelor's degree in Education, and a Master's degree in Educational Psychology, and a Ph.D. from Pennsylvania State University in State College, Pennsylvania.

Q. What degree did you ultimately receive from State College of Pennsylvania?

A. Ph.D.

1 Q. What was that in?

2 A. It was in Human Development, a blend of  
3 developmental and clinical psychology.

4 Q. And after graduating from Penn State  
5 University, what did you do after that?

6 A. I came back to east Tennessee. I began to  
7 work in the community area and I began to work with  
8 the local alcohol and drug coalition group at that  
9 particular time, a council, as they were known, and  
10 then went on for several years with them. In 1989,  
11 that organization merged with a mental health  
12 organization, I think the first happening of that in  
13 the state, in creating a new company blending mental  
14 health and substance abuse addiction services  
15 together. And thereafter maintaining that  
16 organization, we merged with several other  
17 organizations in the years from 1993 -- and in 1997,  
18 the final merger of two other mental health and  
19 substance abuse addiction organizations in our region  
20 to create Frontier Health.

21 At the present time I'm Senior Vice President  
22 of Specialty Services, which includes a lot of  
23 emergency services and various other kinds of special  
24 population service deliveries with mental health and  
25 substance abuse addiction.

1 MR. SWEARINGEN: Permission to approach,  
2 Your Honor?

3 THE COURT: Yes.

4 BY MR. SWEARINGEN:

5 Q. Dr. Jessee, I've handed you a document that  
6 we've premarked as Exhibit 390. I'll ask you to take  
7 a look at that and see if you recognize it.

8 A. Yes, I do.

9 Q. And what is that document?

10 A. The document is basically -- I think it's a  
11 recent bio, biography, which is done through our  
12 public relations unit inside our company.

13 Q. Does this biography set forth some of your  
14 education and relevant clinical experience serving  
15 east Tennessee and southwest Virginia?

16 A. Yes, yes, it does.

17 Q. And I may have missed it: When did you move  
18 to east Tennessee and first --

19 A. We came back from Pennsylvania in 1978.

20 Q. Since that time have you been actively and  
21 clinically practicing in --

22 A. Yes, I have.

23 MR. SWEARINGEN: Your Honor, I ask this  
24 be introduced as Exhibit 390.

25 THE COURT: Exhibit 390 we've marked as

1 the biography of Randall E. Jessee.

2 (Marked Exhibit No. 390.)

3 BY MR. SWEARINGEN:

4 Q. And, Dr. Jessee, you mentioned this: What is  
5 your current role at Frontier Health?

6 A. Sir, I'm the Senior Vice President of  
7 Specialty Services. Again, that's a division that  
8 includes our crisis services, regional crisis  
9 stabilization unit to alcohol and drug detoxification  
10 and rehabilitation units and domestic violence and  
11 various other kinds of services. They are special  
12 populations, community justice programs that deal with  
13 incarcerated individuals and several others.

14 Q. There's been a lot of testimony thus far in  
15 this case about the Woodridge Psychiatric Hospital.  
16 Are you familiar with that institution?

17 A. I certainly am. I was the administrator at  
18 Woodridge from 2003, '04 and part of '05.

19 Q. Was Woodridge, prior to its purchase by  
20 Mountain States, owned by your company, Frontier  
21 Health?

22 A. Yes, it was. It was part of the merged  
23 organizations, Watauga Mental Health Center, that was  
24 brought into the company and was operated by Frontier  
25 Health, yes.

1 Q. And what years were you the administrator?  
2 Administrator, is that sort of like a CEO?

3 A. Yeah, in today's terms that probably would be  
4 the case. I was there I believe from '03 through '05,  
5 spring of '05.

6 Q. And from '03 to '05, do you recall what the  
7 average census levels were at Woodridge?

8 A. Yeah, our goal was 85 percent, and we averaged  
9 between 60 and 65 patients, to my recollection.

10 Q. And for the Court's reference, back in 2003  
11 through 2005, how many beds did Woodridge have?

12 A. Seventy-five.

13 Q. And why did Frontier Health sell Woodridge  
14 Psychiatric Hospital?

15 A. Well, the state of Tennessee at the time under  
16 TennCare had a waiver I think with CMS, and the  
17 process of that waiver allowed free-standing  
18 organizations to have more than 16 beds in psychiatric  
19 service. And when that waiver was given up by the  
20 State, then it had to be attached to an acute care  
21 hospital. We could no longer operate it after losing  
22 that waiver under what was called the IMD rule; so we  
23 had to sell it or turn it into something other than a  
24 public provider organization, public psychiatric  
25 facility, that we had maintained it as. And we did

1 not want to do that, to turn it into a Medicare  
2 facility or some other kind of facility that could  
3 have been operated outside of that particular  
4 exclusion; so we felt like we did have to sell it, and  
5 we ended up making that sale to Mountain States.

6 Q. And did Frontier Health have any conditions on  
7 the sale of the facility in order to continue this --

8 A. Yeah, I believe in that contract there was a  
9 requirement for them to maintain it as a public  
10 provider organization for five years. I'm pretty sure  
11 that's correct.

12 Q. And through your experience, has Mountain  
13 States met those obligations in its operation of  
14 Woodridge?

15 A. Oh, yeah. Far beyond. They're operating that  
16 way today. They are the safety net provider, public  
17 provider in the region, yes.

18 Q. Tell us a little bit about Frontier Health,  
19 your organization, and what it does.

20 A. Sure. Frontier Health is a regional  
21 organization that provides a wide variety of  
22 psychiatric and psychological intellectual disability  
23 and other kinds of service in an eight-county region  
24 of upper East Tennessee, and we also have contracts  
25 with three counties in southwest Virginia to provide

1 those kind of services.

2           Frontier Health is established to try to  
3 develop a continuum of care and comprehensive  
4 continuum of care, and as much as possible, provide as  
5 many of the needs and gaps of services in the  
6 communities that we serve as possible. As such,  
7 that's why we do all those different things,  
8 psychosocial programs, employment training and job  
9 placement, transportation, group homes, inpatient,  
10 detoxification and rehab services, special population  
11 services with women, pregnant women, and geriatric  
12 patients as well. We do things, like I said,  
13 domestic -- we work in domestic violence and in  
14 community justice areas working to identify inmates  
15 prior to them being incarcerated or even after they  
16 are incarcerated in a detention center or jail to get  
17 them services, identified and get them services while  
18 they're there. We do, like I said, crisis, regional  
19 crisis, which includes children and youth crisis  
20 services and a crisis stabilization unit, which is an  
21 adult unit presently as well, intensive out-patient  
22 services and regular out-patient services, case  
23 management for those individuals and many, many other  
24 kinds of services. I could probably speak a long time  
25 about those.

1 Q. How many patients did Frontier Health see last  
2 year?

3 A. I think over 40,000 independent cases.

4 Q. As the out-patient and crisis provider, does  
5 Frontier interact with Woodridge and Mountain States?

6 A. Oh, yes. Our role in the community, again,  
7 has been fostered and developed by partnering with  
8 organizations. And as a community provider, those  
9 partnerships are really crucial. Our partnership with  
10 the Mountain States folks and Woodridge is a  
11 significant endeavor. Our crisis teams are in the  
12 emergency rooms working in various areas. Our  
13 referral agents are around the community in those  
14 eight counties in the process of doing their  
15 evaluations. In those emergency departments we have  
16 to work closely with the psychiatric hospital, and  
17 Woodridge, being our local facility primarily, we work  
18 very closely with them. We work on various kinds of  
19 things in dealing with recidivism, with the inpatient  
20 admission process and coordination of care, all those  
21 kind of things, because most of these folks that are  
22 coming and going between services, we are the primary  
23 provider in that region; so those folks are coming  
24 back out into the community.

25 So it's really crucial -- in fact, we have

1 case managers that work in Woodridge in trying to  
2 identify folks and help them on the way out to connect  
3 so that we don't really lose folks. It's really easy  
4 to do that if you're not kind of warm hand walk them,  
5 you know, from one door to the next making sure that  
6 they get into the services that they need to follow-up  
7 with. So our history working with Woodridge is  
8 long-standing since we sold it.

9 Q. You spoke a little bit earlier about a crisis  
10 stabilization unit, and that's been talked about a  
11 little bit in this case, but I'm not sure anybody has  
12 ever really explained what that is. My understanding,  
13 does Frontier Health currently operate an adult crisis  
14 stabilization unit?

15 A. Yes, it's a 15-bed unit in Johnson City.

16 Q. Explain what that crisis stabilization unit is  
17 and how it operates and how people or patients are  
18 referred to it.

19 A. Well, a crisis stabilization unit is an  
20 intermediate level of care. There are various levels  
21 of care, and you try and put somebody when you  
22 evaluate them to place them in an appropriate level of  
23 care, the least restrictive care that their condition  
24 would require. So a crisis stabilization unit would  
25 handle individuals that had some acute conditions,

1 decompensation if they had psychotic issues, various  
2 kinds of mood, thought and behavior issues that come  
3 from high levels of stress in their environment. And  
4 that process, they may be off their medications to  
5 handle those, they would have a medication review  
6 assessment evaluation. And usually, again, the crisis  
7 team is seeing these individuals as they are out  
8 working, because they're mobile in the community. So  
9 as those folks are identified, then we have to come up  
10 with some way of responding to what kind of care that  
11 they need.

12           A crisis stabilization unit provides a level  
13 of care prior to psychiatric hospitalization. You  
14 know, safety is a real key issue in the process as  
15 well. So what we're trying to do is place someone in  
16 a safe environment. If they're safe to go home, and  
17 that evaluation indicates that, then you can do that.  
18 Or if they're safe to go to out-patient, then those  
19 levels are determined by that therapist, Master's  
20 level therapist is who an MPA, mandatory pre-screening  
21 agent, that is certified by the Department of Mental  
22 Health here in Tennessee. So they make those  
23 evaluations and try to work with the available  
24 services to put that person in the right level of  
25 care.

1           A crisis stabilization unit takes some  
2 difficult situations, it's right up to the limits of  
3 psychiatric hospitalization. But, you know, violence  
4 and other kinds of issues and other behaviors that a  
5 person might have that would indicate they need a  
6 higher level of care would be moved then into a  
7 psychiatric hospital or sent directly, or if they  
8 required more one-on-one observation than we're able  
9 to provide, that would also be transferred into or  
10 sent directly to a psychiatric hospital. A CSU is  
11 staffed by nurses, RNs, therapists, case managers,  
12 residential techs that work alongside the individuals  
13 watching and observing them during their day in that  
14 unit. They have treatment during that day, they see  
15 the doctor, the doctor rounds every day and talks with  
16 the patient. There was either a medication history  
17 and doing a medication evaluation -- excuse me, I  
18 apologize for my voice.

19           THE COURT: That's okay.

20           THE WITNESS: And in that process try to  
21 determine what would be the best ways in order to get  
22 this person re-stabilized. In many cases the group  
23 therapy process is indicative of how that would go and  
24 what kind of referral they would receive after  
25 discharging from that facility.

1           A CSU is anywhere from 24 to 96 hours,  
2           and in that period of time it's an intensive  
3           environment. If you were to be there, you could  
4           really get the sense of that. As a group of  
5           individuals, those folks receive individualized care,  
6           and that increases the intensity, as well as the group  
7           care. Individual and family therapy is also part of  
8           that kind of a situation.

9           BY MR. SWEARINGEN:

10          Q.           Do you consider a crisis stabilization unit to  
11          be a waiting room for future inpatient hospitalization  
12          or is it an alternative?

13          A.           Well, it is an alternative, but the primary  
14          goal is to get folks back out into the community, hook  
15          them back up, not to send them on to a psychiatric  
16          hospital. If they come in to the crisis stabilization  
17          unit, our goal is to get them to the point that  
18          they're stabilized that they can get back into the  
19          community, reconnect with out-patient and other kinds  
20          of services, and if they're involved in self-help  
21          groups, and those kind of things and family to work  
22          all of that as a support system back into their lives,  
23          hook them back into their case management process and  
24          those kinds of things.

25          Q.           And you've talked about an adult, the adult

1 CSU that Frontier Health currently operates?

2 A. Yes.

3 Q. Does Frontier Health have plans currently also  
4 on the child and adolescent side?

5 A. Yes, we do. That is an issue that has been  
6 part of the regional mental health planning group,  
7 which is part of the state council from the department  
8 for a while. So that has been a goal for us, and we  
9 have recently in the last year began --

10 Q. I'm not trying to run you dry. If you need  
11 some water.

12 A. Well, I have no idea why this just jumped on  
13 me. In the process of that thought and development,  
14 began working with Mountain States Health Alliance in  
15 order to partner on this process. And we're  
16 finalizing efforts now with them in terms of -- I've  
17 identified a facility in which they will renovate and  
18 help us place that facility. We have created the  
19 proposal, staffing and protocols and things like that  
20 for operation, and been in discussion with managed  
21 care organizations, TennCare, and with the Department  
22 of Mental Health around the payment process and also  
23 with around licensing, you know, that facility. So  
24 those are all processes that are finalizing, I guess,  
25 positions.

1           We have I think -- we feel very good about  
2 those possibilities that it's going to happen because  
3 the state individuals in TennCare and the department  
4 are very supportive of that process. So far we have,  
5 I think, gotten support from Mountain States as well  
6 in this process, in this partnering endeavor. Again,  
7 that would help us I think in the community much like  
8 the adult unit.

9           You have, and especially with children and  
10 adolescents in this case, who from their life  
11 experiences with families being one-parent families,  
12 many, many of those these days -- and other kinds of  
13 situations, and they may have conditions other than  
14 just life events that help produce stresses and things  
15 that create those debilitating and incapacitating kind  
16 of emotional situations where they either mood wise,  
17 emotionally, behaviorally, are not able to live their  
18 daily life in a functional manner. So those folks  
19 usually end up in an emergency room, and our crisis  
20 team would end up seeing those. Because we have the  
21 children and youth section, we have to find some  
22 disposition for them. And previously we really didn't  
23 have much of an opportunity. So the CSU for children  
24 and youth, in this case mostly adolescents 12 and up,  
25 we thought was very crucial, a component for the

1 community in terms of service delivery. So our  
2 commitment to it is there, and I think the Mountain  
3 States' commitment and the rest of the partners in  
4 this process.

5 Q. And do you, as with the adult CSU that you've  
6 already described, is it your hope and expectation  
7 that the adolescent CSU will serve as an alternative  
8 for adolescents to inpatient hospitalization?

9 A. Well, yes, absolutely. With limited resources  
10 on the children and youth side anyway, this is a real  
11 key component. And the fact that we have a large  
12 program in the region as well of various kinds of  
13 services, including foster care, I think all the more  
14 makes us capable of working from that kind of level of  
15 care back into the community, again, keeping folks --  
16 the goal is really to keep people out of  
17 hospitalization as much as possible.

18 MR. SWEARINGEN: Thank you, Dr. Jessee.  
19 That's all the questions I have for you right now.

20 THE WITNESS: Yes, sir.

21 CROSS-EXAMINATION

22 BY MR. WEST:

23 Q. Good morning, Dr. Jessee.

24 A. Yes, sir.

25 Q. I'm Bill West, the lawyer for SBH-Kingsport,

1 LLC.

2 A. Mr. West.

3 Q. It's good to meet you. I'm going to ask you  
4 some questions now. If at any time you need to take a  
5 drink from your water bottle, I understand, because I  
6 think we've all had similar experiences in this room  
7 with the air conditioning.

8 A. Unfortunately, yeah, I don't know. Hotels  
9 make a big difference, too. You spend three days in a  
10 hotel for business and stuff, yeah, it's different. I  
11 apologize.

12 Q. That's all right. I wanted to go just into a  
13 little bit of your background so we can understand it  
14 better. And I know you've been in East Tennessee for  
15 a long time. Are you a native of upper East  
16 Tennessee?

17 A. I was born in Bristol, Virginia, and raised on  
18 the Tennessee side. We lived in Fort Lauderdale,  
19 Florida for about a year, returned, and I went to high  
20 school at Tennessee High in Bristol, and then on to  
21 the University of Tennessee from there.

22 Q. I assume Tennessee High is in the Bristol,  
23 Tennessee division?

24 A. Yes, it is.

25 Q. And you received your Ph.D. at Penn State in

1 '78?

2 A. I did sir, yes.

3 Q. And what is your licensure status in  
4 Tennessee? Are you a clinical psychologist or what is  
5 it exactly? Where do you fall on the --

6 A. I'm a licensed professional counselor with  
7 mental health provider status.

8 Q. And what is the difference between that -- I  
9 understand they don't truly call them clinical  
10 psychologists anymore in Tennessee.

11 A. Yeah.

12 Q. What is the difference between your licensure  
13 status and a clinical status?

14 A. The clinical psychologist program requires an  
15 internship, and that internship I did not have. So  
16 when I came back here I wanted to do that, but I would  
17 have to not work and go and do this. I couldn't  
18 afford to do that; so the next available opportunity  
19 for me was that licensed professional counselor; so  
20 that's what I decided to do.

21 Q. I understand.

22 A. That allows me to work with insurance patients  
23 as well as commercial and TennCare and Medicare and  
24 all those other kinds of services that are insurance  
25 related, as well as public provider grants, those kind

1 of things.

2 Q. And you, yourself, can treat or have treated  
3 patients in Frontier or somebody that it's been billed  
4 for to the payors?

5 A. Yes, I have over the years. I didn't see huge  
6 numbers of people, but I did, yes, keep up some  
7 practice, yes. I presently do not see anyone. I just  
8 don't have time anymore to do that.

9 Q. I understand. And the organizations, you  
10 described a fairly complex corporate merger process  
11 throughout Frontier's development --

12 A. Yes.

13 Q. -- but the organizations themselves that make  
14 up Frontier have been around a good bit longer than  
15 Frontier itself?

16 A. Well, yeah. Since 1957, I think the first  
17 organization, '57, '59, most of them. The last one  
18 was the Greenville Nolachuckey Mental Health Center,  
19 which I think was established in 1972.

20 Q. I note on your website that there is a picture  
21 in the history page of -- I think it's the Kingsport  
22 Mental Health Center front door or something, looks  
23 like an old picture?

24 A. Yeah.

25 Q. And when you spoke in the process of your

1 organization selling Woodridge to Mountain States, you  
2 spoke of a waiver program. So, essentially, let me  
3 see if I understand it, the state -- it was about to  
4 be treated as an Institute of Mental Disease or the  
5 IMD?

6 A. Well, that law was put on the books I believe  
7 in 1967. The IMD rule, Tennessee under TennCare, a  
8 development of TennCare, had a waiver for  
9 free-standing hospitals to receive Medicaid payment.  
10 The governor at that time made a different deal, so to  
11 speak, with CMS, and that has been altered, gave that  
12 away. So anybody who had more than 16 beds you either  
13 had to change it or connect it to an acute care  
14 hospital. We were not a hospital association or  
15 organization at that point. We would have liked to  
16 have kept it.

17 Q. I understand. You mentioned that Frontier  
18 serves three counties in southwest Virginia. Can you  
19 name those?

20 A. Yes, sir, we have a contract with what is  
21 called Planning District One, which is under the CSP  
22 board process in the state of Virginia.

23 Q. And what are those counties?

24 A. Lee, Scott, and Wise.

25 Q. Dr. Jessee, you made a reference several times

1 to Frontier partnering with Mountain States Health  
2 Alliance?

3 A. Yes, sir.

4 Q. Is that a partnership in a formal legal sense  
5 in the sense of signing/executing partnership  
6 agreements?

7 A. We have -- there's basically two levels. With  
8 the CSU, yes, there will be those kind of things, and  
9 those kind of things are already in process. As an  
10 overall partnering process as a community partner, we  
11 seek out other organizations, and we connect with  
12 them, we plan with them, we have various meetings and  
13 joining the organizations with similar goals and  
14 trying to achieve the best outcomes for the community.  
15 We cannot have all the resources that are needed in  
16 order to do that. I mentioned comprehensive continuum  
17 of care. That is a goal, but it's not certainly a  
18 perfect kind of process. And over the years  
19 organizations, larger organizations, hospital systems,  
20 we do the same thing with Wellmont on the other side  
21 of the region. And we did that with HCA when they  
22 were around and owned hospitals there as well and  
23 other smaller organizations. The mergers were related  
24 to economies of scale.

25 Q. I understand. So in one sense when you use

1 the word partnership, you're talking more of a  
2 collaborative effort as opposed to a formal legal  
3 partnership?

4 A. Yes. I think in the CSU, the C&Y CSU, there  
5 were more formal documented kinds of things that would  
6 occur.

7 Q. You said C&Y. Is that children and youth?

8 A. Yes, children and youth. I'm sorry.

9 Q. So the same thing as child and adolescent?

10 A. Child and adolescent, yes.

11 Q. Just trying to keep the acronyms straight  
12 here.

13 A. Yes.

14 Q. And what would be the nature of that  
15 partnership, the legal partnership between Frontier  
16 and Mountain States in the child and adolescent CSU?

17 A. We will have a lease agreement on a building  
18 and an agreement that establishes us and working to  
19 operate and manage that particular service in that  
20 facility.

21 Q. Excuse me. I cut you off. I'm sorry.

22 A. That's all.

23 Q. In that relationship, will Mountain States  
24 share in the revenues from the CSU?

25 A. No. We will do the building and it will be

1 our endeavor. It's our responsibility, it's our risk.

2 Q. We've been told by Dr. Trivedi, for example,  
3 that the Mental Health Department does not favor or  
4 permit hospital systems to operate CSUs. Has that  
5 been communicated to you as well?

6 A. I'm not aware of that, if that's the case. I  
7 think you have to have CSU experience, which we do.

8 Q. Right. Can you provide the record and the  
9 Court with some information and us with some  
10 information about what is the reimbursement per day  
11 anticipated for the adolescent CSU, child and  
12 adolescent CSU?

13 A. Well, that is not established, but you're  
14 looking at a range of rates that are potential. I  
15 believe that TennCare will set the rate for the MCOs  
16 rather than allowing us to negotiate separately with  
17 those MCOs, and I do not know what that exact rate  
18 would be. If you're asking me have I calculated in  
19 this process of working with them what I think a  
20 needed rate is, then I could tell you that.

21 Q. Well, tell us that.

22 A. Okay. I think the rate range was between 475  
23 and \$500.

24 Q. And Frontier operates the current adult CSU in  
25 Johnson City; is that correct?

1 A. Yes.

2 Q. Does that have a name other than the CSU?

3 A. No, it's crisis stabilization unit.

4 Q. All right.

5 A. It says Frontier Health Crisis Stabilization  
6 Unit.

7 Q. And is that funded by TennCare or the  
8 Department of Mental Health?

9 A. There are uninsured dollars that are provided  
10 by the Department of Mental Health, and that being  
11 70 percent roughly of the folks that come into that  
12 unit are uninsured.

13 Q. And what is the --

14 A. Thirty percent is the MCOs.

15 Q. All right. What is the reimbursement per day  
16 or what are the charges per day of the adult CSU?

17 A. Well, the charges are usually greater than the  
18 reimbursement rates in our business.

19 Q. Believe me, I understand.

20 A. So they pay us a per diem rate, and that per  
21 diem rate for the uninsured from the state's side is  
22 \$300 a day. The MCO rates vary, and I don't know if I  
23 can accurately remember all those rates, but they  
24 average close to \$360 or 70 a day.

25 Q. And do you know the charges that, the charges

1 that are made, even though they're not paid, the  
2 charges that are made per day at the adult CSU?

3 A. I know what the bottom line is, how much it  
4 costs us to operate that facility on an annual basis,  
5 and we get those monthly reports. Yes, sir, I do.

6 Q. What is that?

7 A. The actual cost to operate the CSU is close to  
8 \$2 million.

9 Q. And how does that work out per day?

10 A. I don't know if I've calculated that out. So  
11 what you have to do is be extremely efficient and  
12 effective with how you manage your money, and that we  
13 do our best to do.

14 Q. Let me ask this also while we're on the CSU  
15 topic. How many beds does the adult CSU have?

16 A. Fifteen.

17 Q. And how many beds are projected for the child  
18 and adolescent CSU?

19 A. Twelve.

20 Q. And the adult CSU has been open since 2009?

21 A. Yes, sir, it has. Usually when you open a new  
22 service, it's a developmental process, and you have to  
23 work very hard on the front end. But, again, because  
24 of our nature I think in the history, in the community  
25 and whatnot, our ability and people's knowledge of us,

1 our positive feelings about the process and the  
2 project are high.

3 Q. For the child and adolescent CSU, when did  
4 this development process start that you've just  
5 referenced for the development of that child and  
6 adolescent CSU?

7 A. It's been within the last year, year and a  
8 half. I think initial conversations -- I couldn't  
9 give you an exact date.

10 Q. All right. And when you speak of initial  
11 conversations, with whom did those take place?

12 A. Those probably took place between our CEO and  
13 individuals in Mountain States. The process in the  
14 community, this kind of an ongoing dialogue, so things  
15 are discussed in various ways.

16 Q. When you say your CSU, your CSU now is  
17 Dr. Kidd; is that right?

18 A. Yeah. Our CEO is Dr. Terri Kidd.

19 Q. Were those conversations with her or with her  
20 predecessor at the beginning of this developmental  
21 process?

22 A. Probably may have began with the predecessor.  
23 I don't have direct --

24 Q. Who was her predecessor? Was it Mr. Good?

25 A. Charles Good, yes.

1 Q. Going back to the proposed child and  
2 adolescent CSU, I know you've spoken of it as a  
3 partnership, but you won't be sharing revenues with  
4 Mountain States, will you?

5 A. No.

6 Q. And Mountain States will be leasing a building  
7 to Frontier for the purpose?

8 A. They will, yes.

9 Q. They'll be your landlord?

10 A. They will. They will renovate the building to  
11 the specs that we have established with them in  
12 conjunction with them.

13 Q. Has that renovation started?

14 A. No, it has not.

15 Q. Mountain States, this is a building Mountain  
16 States currently owns?

17 A. Yes, it is, it's in Gray.

18 Q. What's the street address?

19 A. It's on Sunset Drive, Highway 75. The exact  
20 address, it's not too far from where I live, as a  
21 matter of fact.

22 Q. If you could give us an intersection nearby,  
23 that would be helpful.

24 A. Yeah, it's just straight down Highway 75.  
25 Once you get off Interstate 26, it's 1.9 miles from

1 that intersection.

2 Q. Highway 5 from the interstate?

3 A. Highway 75, yeah. It was at one time, I  
4 believe, kind of a First Assist place where you got  
5 kind of immediate needs met for colds and flus.

6 Q. Like an Urgent Care Center?

7 A. Urgent Care Center, yes. That's right.

8 Q. Does the -- well, let me first ask you about  
9 that. The adult CSU, is it just one building or does  
10 it have courtyards and other types of things?

11 A. It is just one building.

12 Q. All right. And this will be just one building  
13 as well?

14 A. Yes.

15 Q. And what's the size of the site? The lot for  
16 this?

17 A. Oh, geez. It's roughly probably two acres.

18 Q. Okay.

19 A. Something like that.

20 Q. And if you're in Gray, you're in Washington  
21 County?

22 A. Yes, sir. You are in Washington County.

23 Q. Will there be any other participants in the  
24 child and adolescent CSU in terms of ownership, other  
25 than Frontier?

1 A. Nope, not that I'm aware of.

2 Q. Dr. Jessee, I am going to show you a document.  
3 It doesn't bear the tag because this is another copy,  
4 but it's been designated as Exhibit 200 in this  
5 matter. It's from the Mental Health Department  
6 website. I'll ask, does that look accurate to you?

7 A. I have seen this before, yes.

8 Q. And this is a list of all the current CSUs in  
9 Tennessee?

10 A. As far as I know, yes.

11 Q. And it says the average length of stay is  
12 three days?

13 A. That's probably -- yeah, I'm sure there are  
14 variations.

15 Q. It's an average?

16 A. Of organizations, yes, uh-huh.

17 Q. So all of these CSUs, whether they're in  
18 Knoxville or Chattanooga or wherever, they're all  
19 operated by I guess mental health centers or  
20 organizations like yours?

21 A. Yes. Many of them are very similar, many  
22 smaller organizations, some larger but, yes, very  
23 similar.

24 MR. WEST: Your Honor, if I may, I would  
25 like to make this Exhibit 200 in this matter.

1 (Marked Exhibit No. 200.)

2 THE COURT: This is Exhibit 200, you  
3 referenced that.

4 MR. WEST: Yes, sir, that was in the  
5 designation on the list exchanged between counsel.

6 THE COURT: All right. So 200 will be  
7 marked document, I believe it was identified the  
8 Department of Mental Health website, and it shows  
9 crisis stabilization units.

10 BY MR. WEST:

11 Q. Dr. Jessee, you're familiar with the rules and  
12 regulations of the Department of Mental Health  
13 concerning CSUs?

14 A. Yes.

15 Q. And is it true that currently those rules  
16 specify that you cannot be younger than 18 to get  
17 admission to a CSU?

18 A. That's correct.

19 Q. So this will actually be the first CSU once  
20 it's done that anyone --

21 A. Under 18, yes, sir.

22 Q. How long has the -- you obviously from your  
23 testimony, believe that there is a need for such a  
24 project in East Tennessee?

25 A. Yes. And, you know, that's based upon some

1 experience from the adult unit and how it filled the  
2 gap and how that's allowed to free up some beds. It's  
3 like a hospital at Woodridge and the ability to have  
4 immediate response to situations that previously  
5 perhaps a person wouldn't, not having that level of  
6 care, would have been sent to a psych hospital. And,  
7 again, issues around that, the whole valuation  
8 process, and sometimes again entertaining safety as a  
9 significant issue.

10 Q. I understand. In the CSUs, what is the role  
11 of physicians, M.D.s, in the CSU that you operate?

12 A. Okay. Well, the rules pretty much allow an  
13 M.D. or nurse practitioner. Frontier Health, we  
14 employ physicians, M.D.s, and in our adult unit we  
15 have Board-certified psychiatrists and internal  
16 medicine dually boarded individuals that provide  
17 services there. In the C&Y CSU, we will have a  
18 pediatric psychiatrist who is head of that and a nurse  
19 practitioner, and the nurse practitioner will work  
20 under the pediatric psychiatrist.

21 Q. In the future adolescent CSU?

22 A. Yes.

23 Q. And what will be the age range of the patients  
24 that are taken?

25 A. Basically 12 to under 18.

1 Q. Dr. Jessee, in your experience working with  
2 various populations in the area, is there ever a time  
3 that it is appropriate to hospitalize a child under  
4 12?

5 A. Yes, that's the case. The predominant number  
6 of cases though are older or adolescents. And usually  
7 younger children require some special conditions.  
8 That's my knowledge.

9 Q. The relationship that Frontier has with the  
10 physicians you mentioned, are they independent  
11 contractors?

12 A. The adult CSU ones are independent  
13 contractors, and one is named under contract as well  
14 as a medical director for our specialty service  
15 division. We have a corporate medical director,  
16 Dr. Allen Musil, who is a pediatrician and a pediatric  
17 psychiatrist who will work in the C&Y unit.

18 Q. So as an employee, he will work in your child  
19 and adolescent CSU?

20 A. Yes. He presently does a predominant amount  
21 of work in conjunction with the out-patient C&Y, and  
22 he also does some adult work.

23 Q. When Dr. Musil does his clinical work now,  
24 does he bill separately or does Frontier bill for  
25 those services?

1 A. No, it's inside Frontier Health.

2 Q. Dr. Jessee, I understand that these crisis  
3 teams you have are mobile and can move around, and  
4 some are located within hospitals here and there?

5 A. Yes, we have -- predominantly it's a mobile  
6 setup, and we have sites. In our own sites we have  
7 crisis workers that are housed there. They're not  
8 there in the building much because they are out in the  
9 community. But they come and they go. And in terms  
10 of those being housed in hospital systems, we do not  
11 have anybody presently housed in a hospital system.  
12 All the calls come into a central dispatch crisis  
13 triage center. Those calls are then logged, and then  
14 the crisis therapists that are on the schedule are  
15 dispositioned out to whatever site through those  
16 triage folks.

17 Q. What is Frontier's -- what is your view as  
18 someone trained in psychology of the health impact of  
19 a patient having to wait two to three days in an  
20 emergency room perhaps, or in some other facility to  
21 gain access to a psychiatric hospital?

22 A. Well, I think, and what my knowledge is in our  
23 area is that there are individuals at peak times  
24 sometimes who do have to spend time there. They are  
25 not abandoned in any way. They are receiving

1 treatment and care and contact. And in often cases,  
2 we will go and reassess them every day while they are  
3 there in that setting. And when all the beds are  
4 filled everywhere, that's kind of -- sometimes that's  
5 what happens. Again, is that an everyday occurrence?  
6 I would say not at any level. But there are peek  
7 times, there are times when the demand is greater than  
8 anybody can handle, whether you're a receiving  
9 hospital or an ER crisis team.

10 Q. What is the occupancy rate of the adult CSU  
11 like for this year?

12 A. Our goal is 80 percent. I think we're  
13 averaging probably between 75 and 80 percent. It does  
14 like any other census process, it goes up and down, up  
15 and down. But we're close to I think our average goal  
16 setting for that.

17 Q. Dr. Jessee, do you recall in late 2013 ever  
18 meeting with any individuals from Strategic Behavioral  
19 Health about a possible psychiatric hospital to be  
20 located in East Tennessee?

21 A. I do recall a meeting with a gentleman. I  
22 don't recall his name.

23 Q. And do you recall the nature of any of the  
24 discussions y'all had?

25 A. He briefly described the organization to us

1 and some of the plan that you had. I know Mr. Good  
2 had more detailed information and encounters with some  
3 folks, but I was not present at those.

4 Q. The folks you just referenced, you mean folks  
5 from Strategic Behavioral Health?

6 A. Some representative, yes, from Strategic  
7 Behavioral Health and other members of the region in  
8 the community in the regions. I think there was at  
9 least one meeting held in Kingsport. But that's  
10 pretty much all I know about it in terms of I wasn't  
11 present.

12 Q. You were present at at least one, right?

13 A. Yes, it was at our corporate office.

14 Q. And that's in Gray, right?

15 A. That is in Gray.

16 Q. Can you recall what you may have told them  
17 about your personal response or Frontier's response to  
18 their proposal or their concept?

19 A. Exact words, probably not. But in terms of --  
20 I think we listened, and I'm not really aware that we  
21 made a definitive statement back to them about  
22 anything really. I don't recall that to tell you the  
23 truth.

24 Q. All right. In the adult CSU, you referenced a  
25 concept called one-on-one observation?

1 A. Yes.

2 Q. How much one-on-one observation does a typical  
3 patient receive in his three or four days at the adult  
4 CSU?

5 A. Well, one-on-one observation is indicated by  
6 present condition, and that is assessed both by the  
7 crisis team, by the nurse on shift, and nursing  
8 assessment process, and in consultation perhaps with  
9 the site director and the attending physician. But  
10 those folks will be placed on one-on-one again for  
11 safety reasons again predominantly. And that is done  
12 to ensure that they are safe while they are there in  
13 that facility. There are certain individuals -- that  
14 is a great responsibility for anybody who is providing  
15 that kind of care when you're in that setting. So  
16 that's provided with those individuals who were  
17 properly assessed, and that will stand as long as they  
18 may be there, or if they worsen, perhaps their  
19 condition worsens in some fashion, then they would  
20 continue to be watched, but they would also be moved  
21 to our higher level of care, but that's just a  
22 standard practice. Basically it is a physician order.  
23 It would be in the chart, as far as I recall.

24 Q. It's a clinical issue?

25 A. Yes, it is.

1 Q. All right. I want to switch topics  
2 momentarily. What is your understanding of the  
3 current occupancy rate of the Woodridge Psychiatric  
4 Hospital in Johnson City?

5 A. In terms of conversations that we have, again,  
6 with meeting with them on a regular basis, the  
7 hospital is being maintained in terms of census at a  
8 pretty high rate. To give you an exact number --

9 Q. That's fine.

10 A. -- I probably can't do that, but it's  
11 approaching being full on many occasions.

12 Q. Do you see the development of the adolescent  
13 CSU that you've been speaking of as a way to relieve  
14 pressure? Pressure is probably the wrong word, but  
15 some of the utilization of the child and adolescent  
16 unit at Woodridge?

17 A. It would definitely do that, yes.

18 Q. How many beds do they have for that purpose?

19 A. I believe there's 14. I couldn't swear to  
20 that, but that's my recollection.

21 Q. There's a map right behind you. I don't know  
22 if you've made use of it. Can you indicate where on  
23 that map or just generally where Frontier has services  
24 or offices?

25 A. Okay. There are 25 offices in this whole

1 region. There is one office in every one of the eight  
2 counties, and in some places there are multiple  
3 offices. In the large counties, Sullivan, Washington,  
4 there are multiple offices. Johnson County is not  
5 there, but Johnson County as well. And those multiple  
6 facilities would include not only out-patient  
7 facilities, but case management units and group homes  
8 and other residential type services as well. But it  
9 would cover all of those and also in those counties,  
10 except Washington and Virginia.

11 Q. I was going to go further; a little more  
12 clarification. Frontier maintains a pretty active  
13 website where people can pull up pages and determine  
14 office locations and that type of thing?

15 A. Oh, yes, we sure do.

16 Q. You have crisis phone numbers and that type of  
17 thing?

18 A. Yes.

19 MR. WEST: Your Honor, if I may, I am  
20 going to show Dr. Jessee a page from the Frontier  
21 website. We haven't previously listed this as an  
22 exhibit, but I would like to ask him about it.

23 BY MR. WEST:

24 Q. Does this look like the map from y'all's  
25 website? From Frontier's website?

1 A. It's been a while since I looked at that.

2 Q. Well, across the top you can see --

3 A. Yeah, sure.

4 Q. -- different types of services and locations  
5 and things?

6 A. Yes, I do.

7 Q. And this is like the general region much like  
8 the map behind you?

9 A. Uh-huh.

10 Q. But it's something that we can file as an  
11 exhibit?

12 A. Yeah.

13 MR. WEST: Your Honor, if I may, I would  
14 like to make this the next exhibit. It's not  
15 previously numbered.

16 THE COURT: So what number are we going  
17 to assign it? 248 will be marked. We have a page  
18 from the Frontier Health website, that will be a  
19 regional map.

20 (Marked Exhibit No. 248.)

21 MR. WEST: Your Honor, if I may, there is  
22 one more exhibit I would like to address that hasn't  
23 been previously numbered, but it's drawn from the  
24 Frontier website. I think it will be helpful in this  
25 regard.

1 BY MR. WEST:

2 Q. Dr. Jessee, could you take a look at this  
3 document I just handed you? Does it appear to be  
4 drawn from the Frontier Health website as well?

5 A. Yes, it does.

6 Q. The things that it lists here in terms of the  
7 services and the locations and things like that, does  
8 that appear to be accurate from your knowledge of  
9 Frontier?

10 A. It is. It's not an inclusive --

11 Q. I understand that there's probably been  
12 changes and additions or whatever?

13 A. Yeah, and it's -- there may be other versions  
14 of this.

15 MR. WEST: I would like to make this the  
16 next exhibit, which would be 249.

17 THE COURT: This exhibit will be marked  
18 249, and it is from the Frontier Health website and  
19 has a designation about patient resources.

20 (Marked Exhibit No. 249.)

21 MR. WEST: Your Honor, that's all the  
22 questions on cross-exam I have for Dr. Jessee.

23 THE COURT: Any redirect?

24 MR. SWEARINGEN: Just briefly, Your  
25 Honor.

REDIRECT EXAMINATION

1  
2 BY MR. SWEARINGEN:

3 Q. Dr. Jessee, Mr. West asked you some questions  
4 about the licensure for CSUs in Tennessee. Do you  
5 recall that line of questioning?

6 A. Yes, sir.

7 Q. Do you have any special expertise as it  
8 relates to licensure of mental health facilities in  
9 Tennessee?

10 A. I'm the chair of the Department of Mental  
11 Health Substance Abuse Services Licensure Review  
12 Board.

13 Q. And is that the board that would make the  
14 final decision as to whether or not this adolescent  
15 CSU would ultimately be approved for service in the  
16 state of Tennessee?

17 A. I believe it is.

18 MR. SWEARINGEN: No further questions,  
19 Your Honor.

20 MR. WEST: That's all I have.

21 THE COURT: You can step down,  
22 Dr. Jessee. Please don't discuss your testimony or  
23 any of the exhibits with anyone else.

24 THE WITNESS: Yes, sir.

25 MR. SWEARINGEN: Your Honor, I should

1 have asked this yesterday for Ms. Bailey, but I was  
2 going to ask for Dr. Jessee be excused and be able to  
3 return to Johnson City.

4 MR. WEST: No objection.

5 THE COURT: That's fine.

6 MR. SWEARINGEN: I think our next witness  
7 is here. We just need a couple of minutes to get set  
8 up.

9 THE COURT: Who is your next witness?

10 MR. JACKSON: It's Dr. Collier, Your  
11 Honor. I'm going to try again. We're going to set up  
12 where I can't trip over and over, but I'm going to try  
13 again with my screen; so it might benefit from a brief  
14 recess, Your Honor.

15 THE COURT: This is probably a good time.  
16 We'll take a short recess.

17 (Recess observed.)

18 THE COURT: You can call your next  
19 witness.

20 MR. JACKSON: Your Honor, please, at this  
21 point in time Mountain States Health Alliance calls  
22 Dr. Deborah Kolb Collier.

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DEBORAH KOLB COLLIER,

was called as a witness, and after having been first  
duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. JACKSON:

Q. Good morning, Dr. Collier. Can you please  
state your name for the record?

A. Deborah Kolb Collier.

Q. You're a consultant in health care planning  
and health care finance; is that right?

A. I am, and I have been for 36 years.

Q. Could you tell the Court a little bit about  
your educational background and professional  
experience in health care planning, please?

A. Yes. I started -- well, educational  
background did not relate to health care. I have an  
undergraduate degree in English from the University of  
Georgia, a Ph.D. in English from the University of  
North Carolina at Chapel Hill, and then an MBA in  
Finance -- well, not in Finance, but with my electives  
taken in Finance from the University of North Carolina  
at Chapel Hill in 1979. After that I began work as a  
consultant with a health care consulting firm, Amherst  
Associates in Atlanta. Subsequent to that, in 1985  
along with some other individuals who are from

1 Amherst, we formed a separate firm, which became  
2 Jennings, Ryan & Kolb, and I was Executive Vice  
3 President of that firm. That was from 1985 until  
4 2002. We sold that company and continued work with  
5 another consulting firm and went through another  
6 transition in 2004. And then in 2009 I started an  
7 independent practice, DKC Consulting, based in  
8 Atlanta. So I have done the same types of consulting  
9 for 36 years but under different organizational  
10 headings, and currently I work independently.

11 Q. Can you give us an idea, Dr. Collier, of what  
12 the nature of your work as a health care planning and  
13 finance consultant is and just kind of give us an  
14 overview?

15 A. Well, there's been a tremendous range over  
16 time. I have done a good deal of Certificate of Need  
17 work, but also strategic planning and financial  
18 planning, financial feasibility, medical manpower  
19 planning, just a wide range of activities.

20 Q. Have you worked for health care facilities in  
21 the state of Tennessee in assisting them with their  
22 health care planning?

23 A. I have. I have worked for Vanderbilt. I did  
24 the strategic plan for their orthopaedics department.  
25 I worked with them on their managed care plan. I

1 worked with Wellmont in their facilities doing  
2 strategic financial planning. I worked with Mountain  
3 States on this project and other CON related work. I  
4 was involved in the original strategic plan when  
5 Baptist and Saint Thomas acquired Middle Tennessee  
6 Medical Center; so it was the first strategic plan for  
7 Middle Tennessee Medical Center as part of that  
8 acquisition. And I continued some work with Middle  
9 Tennessee Medical Center related to CON work. I  
10 worked for West Tennessee Health, for Murray Regional  
11 and Williamson Medical Center in the Spring Hill CON  
12 matter, Covenant most recently on their CON opposition  
13 to the proposed Proton Center in the Knoxville area.  
14 So those are some of the range of projects in  
15 Tennessee.

16 Q. Have you, over the course of your profession,  
17 Dr. Collier, worked on psychiatric projects, projects  
18 involving psychiatric care?

19 A. I have. It's been a while since I have worked  
20 on a psychiatric CON, but I have done those in the  
21 past and a feasibility study for a psychiatric  
22 free-standing hospital. More often it's been  
23 strategic business planning as to psychiatric services  
24 for hospitals in the line of doing business planning  
25 and strategic planning.

1 Q. Do you take every case that's presented to  
2 you, Dr. Collier?

3 A. No. I'm in a condition I would call  
4 semi-retirement; so I turn down a lot more projects  
5 than I take these days.

6 Q. What are the criteria that you use or some of  
7 the criteria that you use in deciding whether to take  
8 a case, act as a consultant in a CON case like we're  
9 here today about?

10 A. Well, in a CON case, one, I have to like  
11 working with the attorneys.

12 Q. Well, thank you.

13 A. It has to be a client, it has to be either an  
14 existing client that I know and know that I will have  
15 a good relationship with and be responsive to what I  
16 need, and it has to be a project that I think is  
17 appropriate.

18 Q. Your CV you've included, and we're going to  
19 make an exhibit in a minute of your report, but your  
20 report includes as an appendix, Appendix A, I believe,  
21 your CV with your professional background, training,  
22 education, experience, your various publications;  
23 right?

24 A. Yes, it is.

25 Q. Now, you've been retained by Mountain States

1 to evaluate the application in this case for a new  
2 hospital in Kingsport; is that right?

3 A. Yes.

4 Q. Tell us sort of in summary, first, what all  
5 you did and how you went about preparing your opinions  
6 and report in this case.

7 A. Well, typically, and as I did in this case, I  
8 requested the staff report. There was a transcript of  
9 the public hearing. I reviewed those before I agreed  
10 to proceed with the case. After we agreed that I  
11 would work on the case, I received all the file that  
12 was available at the time and began data gathering,  
13 looking at demographic sources, such as the Tennessee  
14 Department of Health population projections. In this  
15 case, the Virginia population projections were also  
16 part of the source material. I looked at Clara Toff's  
17 (CHECK THIS) population. I also looked at statewide  
18 information that's available through the joint annual  
19 reports of hospitals. In this case, Mountain States  
20 was able to provide the hospital discharge data base  
21 from the Tennessee Hospital Association; so I was able  
22 to get hospital data from that source as well. I  
23 looked at use rates, utilization, the basic types of  
24 information that you would expect to look at in  
25 reviewing or in developing a CON application.

1           As discovery continued, obviously I had access  
2 to all the discovery documents, and I assisted  
3 Mountain States in asking for information that I felt  
4 would be important to get from strategic business,  
5 strategic behavior, and SBH, I'll call it. So as  
6 depositions came in, as discovery documents came in, I  
7 reviewed all of those. I reviewed general information  
8 about psychiatric and substance abuse services, some  
9 of the same national data that Mr. Sullivan reviewed.  
10 And, of course, I reviewed his report and all of his  
11 exhibits that were provided. So there was a wide  
12 range of material that I reviewed in the course of  
13 putting together my report.

14           Q.       Once you had reviewed all this material,  
15 Dr. Collier, did you prepare a written report that  
16 summarizes your opinions in this case, the bases for  
17 those opinions and the materials you reviewed?

18           A.       I did.

19           Q.       I've put before you so that I don't have to  
20 walk over there, I've put before you Exhibit 381,  
21 which I've marked as a color copy of your report. If  
22 you could please identify whether or not that is a  
23 copy of your report that sets out your opinions in  
24 this matter?

25           A.       It is.

1 MR. JACKSON: Your Honor, please, I would  
2 tender that as Exhibit 381 at this time, and I have an  
3 extra copy for Your Honor, too.

4 THE COURT: Exhibit 381 will be made the  
5 expert report of Dr. Collier and has the date of July  
6 10th, 2015.

7 (Marked Exhibit No. 381.)

8 BY MR. JACKSON:

9 Q. Dr. Collier, we've already heard in this case,  
10 just to move things along, about the three big  
11 criteria, need, economic feasibility, and orderly  
12 development of health care; right?

13 A. Yes.

14 Q. And are those the three prongs of analysis  
15 that you used in your report?

16 A. They are. That's how the report is organized.

17 Q. Let's start with need. Can you explain for us  
18 what's a service area, how is it defined, and how does  
19 it relate to need?

20 A. In this case, of course, the overall heading  
21 of need, then becomes more specific for psychiatric  
22 services, because there is a service specific rule  
23 related to psychiatric need. And that rule hinges in  
24 large part on the definition of service area.

25 Q. What is that rule?

1 A. The rule is a population based rule that  
2 essentially applies a ratio of 30 beds per 100,000  
3 population to a service area. The defined service  
4 area, according to the rule, should be reasonable and  
5 take into consideration population density and the  
6 proximity of services that are similar.

7 Q. So as I understand it, you have to have the  
8 service area in order to do the calculation; is that  
9 right?

10 A. That's correct.

11 Q. So what did you do to determine the  
12 appropriate service area -- let me back up a minute  
13 and ask this. When we say service area, what are we  
14 describing exactly?

15 A. Well, it's the area that accounts for the vast  
16 majority of the patients receiving service at an  
17 institution. And I would agree, I think Mr. Sullivan  
18 said in his deposition and reaffirmed here that it  
19 would account for 90 to 95 percent of your patients.

20 Q. So it's where the patients are going to be  
21 coming from?

22 A. That's correct.

23 Q. And what did you do to come up with what you  
24 believe to be a reasonable service area in this case  
25 with respect to the SBH Hospital in Kingsport?

1 A. Well, first you have to remember that the  
2 applicant proposed a service area. So the first issue  
3 is, is that a reasonable service area, because if it  
4 is, then you use that service area. In this case, I  
5 determined that it was not a reasonable service area,  
6 that it had been gerrymandered, as it were, to exclude  
7 the consideration of psychiatric beds in the  
8 surrounding area.

9 Q. You mentioned that the applicant proposed a  
10 service area. So let me ask you, did the applicant  
11 explain in the application the quantitative basis for  
12 the service area that was claimed?

13 A. No, it did not.

14 Q. Did the applicant in the application offer any  
15 projections as to how many patients would be coming  
16 from any particular county in their claimed service  
17 area?

18 A. No. And typically what I've seen with  
19 applicants, and what I would do as an applicant, would  
20 be to make assumptions and present assumptions as to  
21 the market size by county of the service area, if you  
22 were using counties. In a large urban area you might  
23 use zip codes. But you would break the service area  
24 into county units or zip codes and show the size of  
25 the market and your projected market share of each

1 area; so I would expect to see county case volume,  
2 market share assumption, and a projected volume by  
3 county. The applicant did not do that in this case;  
4 so the whole service area is the only area that was  
5 presented.

6 Q. And, Dr. Collier, you were here when  
7 Mr. Sullivan testified, and you may recall I took him  
8 through the steps that he would take as a health  
9 planner and projected those on the board. Did he  
10 describe a process similar to the process you just  
11 described?

12 A. Very similar.

13 Q. But I take it you didn't see that evidence  
14 that had been done in this case in the application?

15 A. That's correct.

16 Q. So what did you do then to figure out what an  
17 appropriate service area would be for this hospital?

18 A. A couple of things. First, since I was  
19 representing Woodridge and had access to Woodridge  
20 data, too, I wanted to look at Woodridge's service  
21 area and also to find a reasonable proxy for a  
22 facility to be located in Kingsport. And there is no  
23 facility there now; so we're talking about looking for  
24 something that would give me a clue. In this case  
25 there had been a facility in Kingsport, the Indian

1 Path Pavilion, that was a psychiatric hospital located  
2 in virtually the same spot that SBH has selected for  
3 this project development. I think there was a map up  
4 earlier that showed that those sites were within a  
5 mile of each other.

6 Q. So let's start with the Woodridge, and I've  
7 put those exhibits up there. Let me -- I'll come help  
8 you.

9 First of all, these exhibits that we've made  
10 are contained in your report; is that right?

11 A. That's correct. They're in the Appendix B.

12 Q. And just for purposes of our record Map 1 that  
13 I've placed before you is a map of the service area  
14 that was proposed by the applicant in the application;  
15 is that right?

16 A. That's correct.

17 Q. And then you said you looked first at the  
18 Woodridge service area; so I'm going to put up Map  
19 Number 2 in your report. Is that the Woodridge  
20 service area?

21 A. Yes, it is. The box here on the lower side of  
22 the map shows three-year average of the number of  
23 cases by county. So I ranked them, I used three  
24 years, because you can get a shift if you just look at  
25 one year. The next year it might be a little skewed.

1 But over three years, again, the largest percentage  
2 came from Washington County, which is not a surprise.  
3 Second was Sullivan County. And then I ranked them  
4 down to about 90 percent as my cutoff there; so that's  
5 a very large area. And also on the map are indicated  
6 the locations of existing psychiatric facilities as  
7 well as the proposed site. The legend here shows a  
8 ten-mile area. So one thing I noticed about the  
9 proposed service area is that it did not include any  
10 of these counties along the southern side of Sullivan  
11 County and did not include Washington County, most  
12 surprisingly. They looked at the Indian Path service  
13 area.

14 Q. Let me pause for just a moment and ask you a  
15 couple of questions about this, if I could,  
16 Dr. Collier.

17 A. Sure.

18 Q. You said it encompassed a large service area.  
19 Did it surprise you that an inpatient psychiatric  
20 hospital would have a large service area?

21 A. No, it's a more specialized regionalized  
22 service than general community hospital services. So  
23 it was not a surprise. What surprised me was that the  
24 SBH service area was --

25 Q. Which is here (indicating).

1 A. -- was drawn to include this very large area  
2 in Virginia, which extends more than 35 miles to the  
3 corners there, but only extends a short distance south  
4 and, of course, Washington County just being south of  
5 Sullivan County. So that struck me as being strange.  
6 So I wanted to look at Indian Path to see what  
7 historically had been happening there.

8 Q. Is there more population to the south of the  
9 proposed site or to the north off the proposed site?

10 A. Well, Washington County to the south is a very  
11 large population base. These three counties are  
12 relatively sparsely populated. They make up only  
13 30 percent of the population in the five county area  
14 of the service area.

15 THE COURT: And so the record is clear,  
16 those three counties are the three counties in  
17 Virginia; is that correct?

18 THE WITNESS: Correct.

19 MR. JACKSON: Thank you, Your Honor.

20 BY MR. JACKSON:

21 Q. Then before we move on to Indian Path, just  
22 let me ask about Woodridge so we all understand. The  
23 second highest number of admissions was for Woodridge  
24 over the most recent three-year period was from  
25 Sullivan County; is that right?

1 A. That's correct.

2 Q. So I take it that Map 2 reflects your opinion  
3 as to a reasonable service area for Woodridge  
4 Psychiatric Hospital?

5 A. Yes, it does.

6 Q. Then, Dr. Collier -- Your Honor, I'm sorry, I  
7 hope it's okay if I approach. Map 3 shows us what you  
8 discovered about the service area of Indian Path  
9 Psychiatric Pavilion; is that correct?

10 A. That's right. And 2009 was the last year that  
11 Indian Path operated; so I took the last three active  
12 years, 2007 through 2009 and did the same analysis.  
13 This actually adds up to about 89 percent of the  
14 cumulative total over time. Sullivan County was the  
15 number one contributor. 46.3 percent of cases in  
16 Washington was about 12 percent, as was Hawkins. But  
17 Washington did contribute more than Hawkins County did  
18 to the volume of Indian Path over that time period.  
19 And then it did include some of the Virginia counties  
20 as well in this top 89 percent.

21 And I will note that if you extended this down  
22 and went to 95 percent, the next county down on the  
23 list would be Unicoi, and you would also pick up Wise  
24 and you would pick up Russell, Virginia.

25 Q. I think you said Wise. Did you mean Lee?

1 A. I'm sorry. Lee, which is the one over here to  
2 the west.

3 Q. So what did these two analyses tell you about  
4 the service area that was proposed in the application  
5 and what might be a reasonable service area for this  
6 hospital?

7 A. Well, the first thing it told me is that  
8 Woodridge serves a lot of people from the area defined  
9 by SBH as its service area, and it's also heavily  
10 reliant on those cases. So about 36 to 37 percent of  
11 Woodridge's cases come from the five counties that SBH  
12 says that it would serve. And it also suggested to me  
13 that SBH is actually going to be serving more than the  
14 population of those five defined counties if it  
15 develops its project. The proposed service area is  
16 not reasonable and not likely to be the ultimate  
17 service area if the project is developed.

18 Q. As you reviewed the discovery materials in the  
19 case, did you give consideration of whether or not SBH  
20 was likely to market to a service area broader than  
21 the one they identified?

22 A. Well, I think it's clear that they would have  
23 to market it to a broader service area. And it's also  
24 clear that it would be hard not to, in that the  
25 Tri-Cities area is defined by the census bureau as a

1 combined statistical area, meaning there is a lot of  
2 market interaction, commuter interaction, between the  
3 three major population centers of Kingsport, Johnson  
4 City and Bristol. And, you know, the types of  
5 marketing media are not likely to be limited to one  
6 area, so TV ads or magazines or whatever types of ads.  
7 Also, the population growth is occurring south of  
8 Sullivan County in Washington County's primary growth  
9 area, particularly for the child and adolescent  
10 population. So looking at the demographic sources, it  
11 did not make sense to me that a for-profit or  
12 entrepreneurial-type company would go into Sullivan  
13 County and draw a line between it and the growth  
14 market. It would simply not make sense from a  
15 business perspective.

16 Q. Did you even consider what kind of market  
17 share SBH would have to achieve in its claim service  
18 area if it were to meet its volumes of 2,000 cases a  
19 year?

20 A. It would be up around the 75 percent market  
21 share. And then, again, you're talking about part of  
22 that market being in Virginia, a pretty far distance.  
23 So it would be very unlikely that it could achieve  
24 that kind of market share.

25 Q. And, particularly, if you assume that SBH is

1 going to see only -- let's assume for purposes of my  
2 question that it would see only insured patients or  
3 patients with reimbursement. What kind of market  
4 share would they have to achieve in their claimed  
5 service area then to meet their projected volume  
6 targets?

7 A. Well, I think it's in the report but, I  
8 believe, as I recall, the number is approximately  
9 20 percent or so of all the cases from this area are  
10 indigent. So out of the 2,500 cases or so coming from  
11 the SBH proposed service area, about 500 of them are  
12 indigent or self-pay. So assuming for the purposes of  
13 argument that they don't take those cases, that leaves  
14 about 2,000 other cases, and they would have to get  
15 virtually all of those.

16 Q. Is that likely to happen, in your professional  
17 opinion?

18 A. No.

19 Q. Now, did you then, after looking at this data  
20 and studying it, did you come up with your own opinion  
21 as to what a reasonable service area might look like  
22 for this facility if it were built?

23 A. Yes, I did. That is Map Number 8. I  
24 developed that, again, starting with thinking about  
25 the Indian Path as a reasonable proxy because it had

1 similar services, except for the fact that Indian Path  
2 did not provide child and adolescent services. And I  
3 think there has already been testimony that that's  
4 even more regionalized than general adult psychiatric  
5 services.

6 I also was thinking about the access issue. I  
7 looked at a one-hour travel time as a reasonable  
8 access standard and actually drew a circle from the  
9 proposed site and used a 30-mile radius as a proxy for  
10 a one-hour travel time and then chose the counties  
11 that were largely within that 35-mile radius, which  
12 gave me these counties. Then to test that, I had  
13 included as an exhibit to the travel times to some of  
14 the outlying cities just to make sure they were within  
15 an hour. Because the topography here, especially to  
16 the north, is pretty mountainous; so I wanted to make  
17 sure that actually some of those outlying areas like  
18 Norton City would be within an hour travel time  
19 distance. That appeared to me to be reasonable to  
20 assume that 90 to 95 percent of the patients to a  
21 facility in Kingsport would come from these counties.

22 Now, they wouldn't be evenly distributed.  
23 Obviously the majority of them are going to come from  
24 Sullivan and Washington counties because that's the  
25 population base. More than 40 percent of all the

1 population of this area is in Sullivan or Washington  
2 County. And, you know, as you get further away you  
3 have more issues with travel and also education  
4 levels, income levels. The population centers have  
5 the higher education levels, the higher income levels,  
6 probably more educated about mental health services in  
7 general.

8 Q. In your opinion, professionally, Dr. Collier,  
9 is the service area that you've laid out in Map 8 of  
10 your report that we've made Exhibit 381, a reasonable  
11 service area for this facility?

12 A. It is.

13 Q. And, alternatively, if we look at Map 3, which  
14 was the historical service area of Indian Path  
15 Psychiatric Pavilion, would that be a reasonable  
16 service area for this facility with the caveat you  
17 mentioned about child and adolescent beds?

18 A. Yes. I think you can reasonably expect a  
19 little broader service area. But, again, as I said,  
20 if you went to 95 percent, you would have captured  
21 those additional areas.

22 Q. It would look very similar to your Map 8;  
23 would it not?

24 A. It would look identical to Map 8 except it  
25 would have added. Dickinson County also comes within

1 the 95 percent.

2 Q. And you heard Mr. Sullivan used a rehab  
3 hospital in Kingsport and also an acute care hospital,  
4 Indian Path Medical Center in Kingsport, for his  
5 analysis. Are those reasonable proxies for a proposed  
6 new psychiatric hospital, in your opinion?

7 A. I think that Indian Path Pavilion as a  
8 psychiatric hospital is more reasonable. And the  
9 applicant did not use either of those to support its  
10 service area, any of those.

11 Q. Right. But Mr. Sullivan, you would -- I take  
12 it that you would look to a psychiatric facility  
13 rather than a rehab facility in trying to determine a  
14 reasonable market area for this hospital?

15 A. Yes, especially a psychiatric facility located  
16 in the same place.

17 Q. And on that issue, let me show you an exhibit  
18 that we referred to, but I don't think has been  
19 introduced, which is marked as Number 376. Does that  
20 map, I think it's from Google Map or MapQuest. It  
21 says from MapQuest, shows an aerial view of the  
22 relationship between the proposed hospital site and  
23 the Indian Path Psychiatric Hospital that you've been  
24 referring to and that you've set out the admissions  
25 information for in Map 3 of your report?

1 A. Yes. It's less than a mile between the two  
2 sites.

3 MR. JACKSON: Your Honor, we would ask  
4 that 376 be introduced.

5 THE COURT: I know we saw that at some  
6 point during the week, but it's never been made an  
7 exhibit?

8 MR. JACKSON: I don't believe so, Your  
9 Honor. Let's make double sure though. Oh, it has.  
10 Sorry. Never mind. I withdraw that.

11 BY MR. JACKSON:

12 Q. So, Dr. Collier, after you came up with what  
13 you believe -- and let me ask you this: This drawing  
14 of a circle that you did to come up with a service  
15 area, is that similar to what the folks at SBH did in  
16 their internal planning when they were planning for  
17 this facility?

18 A. Yes. That was taken from one of their  
19 discovery documents from one of the presentations.

20 Q. This is what they showed to the Dobbs  
21 Management people, right?

22 A. Yes.

23 Q. And they drew a 25-mile radius and a 50-mile  
24 radius; is that right?

25 A. Yes.

1 Q. And you drew a what?

2 A. 35-mile.

3 Q. So once you took all this information,  
4 Dr. Collier, and came up with what you believed to be  
5 a reasonable service area, did you do a calculation  
6 for bed need?

7 A. Yes, I did.

8 Q. I'm going to put up Exhibit 12 from your  
9 report. That's been marked as Exhibit 381 to our  
10 proceedings. Can you see that okay?

11 A. Yes.

12 Q. Does this -- can you kind of walk us through  
13 what this shows with respect to your calculation of  
14 bed need?

15 A. Certainly. The top -- there are three  
16 segments: The gross bed need --

17 MR. JACKSON: And let's give Your Honor a  
18 chance to find that. I'm sorry, Your Honor.

19 THE COURT: I have it now.

20 MR. JACKSON: Okay. Go ahead.

21 THE WITNESS: There are three sections:  
22 The gross bed need by age, the existing beds in the  
23 service area, and then the net beds needed. And,  
24 again, this is for the alternate service areas I have  
25 defined it. The gross bed need by age group, I

1 segregated the population of children under age five  
2 out of the calculation. The reason I did that is  
3 because SBH specifically said that they are not  
4 serving that population in their CON application, and  
5 they don't serve that population typically. And it's  
6 not generally considered appropriate to put toddlers  
7 in psychiatric hospitals; so that is separate. Then I  
8 have the child five -- well, six and older, and  
9 adolescent group. The adult under 65 and the adult 65  
10 and over. And using the 30 beds per 100,000  
11 calculated each group to show in the highlighted area  
12 the total beds needed, excluding the under five  
13 population ranges from 196 to 202 between 2014 and  
14 2019. And, again, I would point, there are some  
15 population tables that underlie this calculation that  
16 are included in the exhibits that all of, you know,  
17 the growth, most of the growth in that area is in the  
18 additional counties that were not included in the SBH  
19 service area. The child and adolescent population in  
20 their proposed defined service area is declining  
21 rather dramatically; so that's another reason why I  
22 didn't think they would be marketing just to that  
23 area.

24 BY MR. JACKSON:

25 Q. Let's look at that. Go back one slide. You

1 were just there Travis, I think. It may be Exhibit --

2 A. Exhibit 6.

3 Q. Yeah, go back to the one before that. Yeah.

4 I'm sorry. Exhibit 6, does this show what you're  
5 talking about?

6 A. It does. It shows for the five-year planning  
7 horizon that I used the bars, the negative bars there,  
8 are for Sullivan County and the proposed service area  
9 altogether. So in Sullivan County, the child and  
10 adolescent population is projected to decrease by  
11 5,800 for their five county proposed service area.  
12 The child and adolescent population is projected to  
13 decrease by 8,000, while the Washington County  
14 population for that child and adolescent group is  
15 increasing. But even with the Washington County  
16 growth, if you look at that whole area that I defined  
17 as a reasonable alternate service area, there's still  
18 an overall net projected decrease in the child and  
19 adolescent population; so they're proposing a large  
20 28-bed child and adolescent unit again for a  
21 significantly decreasing population in their defined  
22 service area.

23 Q. On that point, how many child and adolescent  
24 beds are they proposing to put into this unit?

25 A. Twenty-eight, I believe.

1 Q. And even under their service area, is there a  
2 need for 28 additional child and adolescent beds,  
3 according to the State Health Plan formula?

4 A. No, there is not.

5 Q. And that's acknowledged by Mr. Sullivan in his  
6 report; right?

7 A. Correct.

8 Q. Go ahead.

9 A. So back to the bed need calculation in  
10 Exhibit 12.

11 Q. For our record, this is Exhibit 12 of Exhibit  
12 381; is that right?

13 A. That's correct.

14 Q. Okay. Go ahead.

15 A. So in 2019 it shows, again, a decrease from  
16 2014 from 10.3 to 10.1 beds, gross bed need for the  
17 under 5. A decrease in the child 5 and over and  
18 adolescent population from 31.2 to 30.1. The adult  
19 under 65, the 2019 need is 126.9, and for the adult 65  
20 and over it's 44.6. So a total of 211.7. But if you  
21 exclude the under 5 it's 201.6 or say 202 beds. And  
22 then, according to the rule, you then adjust for the  
23 beds that are already there.

24 So I've listed the total inventory 12 child  
25 and adolescent beds at Woodridge, 118 adult beds, but

1 non-age specific, and 42 that are identified as being  
2 geriatric, which could be 65 and over or could be some  
3 under 65 if they have geriatric-type problems; so a  
4 total of 172. And then just subtracting the beds that  
5 are available from the beds needed shows at the very  
6 bottom the total beds needed, excluding the under 5 is  
7 30 beds, which would be 18 beds for child and  
8 adolescents, 9 beds for under 65, and about 3 beds for  
9 over 65.

10 Q. Dr. Collier, using a reasonable service area,  
11 is there any way to generate a need for 72 beds,  
12 psychiatric beds, in this area?

13 A. No, not that I'm aware of.

14 Q. Now, did you also look to see how busy  
15 existing facilities were?

16 A. Yes. Again, under the rules you look for  
17 utilization of similar services in the area. Of  
18 course, I think that the area that's appropriate to  
19 look at is larger than the defined SBH service area.  
20 So within the alternate service area, Exhibit 15  
21 attached to my report shows the last three years that  
22 are available from the joint annual reports of  
23 hospitals, chose the total beds, the discharges, the  
24 average length of stay, and the occupancy percent.

25 Q. And we've heard a lot in this case about

1 Woodridge, but we haven't heard much about these other  
2 providers; so let's start with those. What are the  
3 occupancy rates of all these other area psychiatric  
4 providers, Dr. Collier?

5 A. Well, the sort of pink and yellow areas show  
6 the adult beds and the total beds. So just going to  
7 the total beds, the yellow area --

8 Q. Is that at the bottom of the page of  
9 Exhibit 15 to Exhibit 381?

10 A. Yes. Of the 172 beds, the average percent  
11 occupancy in 2013 was approximately 63 percent.

12 Q. Is that occupancy percentage, in your opinion,  
13 an indication that there is some crisis in  
14 availability of inpatient resources in this area?

15 A. No, it would not indicate that.

16 Q. And you know the last year Woodridge reported  
17 here is I believe 2013; is that right?

18 A. That's correct.

19 Q. And you've heard the testimony and you know  
20 that Woodridge utilization has increased in the last  
21 couple of years; right?

22 A. Yes.

23 Q. Is it unusual, in your experience, or a cause  
24 for concern, that a hospital may occasionally be full?

25 A. No.

1 Q. Tell us about use rate. What is use rate?  
2 And let's be real clear what we're talking about when  
3 we talk about use rate of inpatient psychiatric  
4 services. Just so we're all on the same page, when we  
5 talk about that, we're talking about identifying how  
6 many people are put into a psychiatric ward of a  
7 hospital; right?

8 A. That's correct.

9 Q. And is talking about the use rate for  
10 inpatient psychiatric services the same as talking  
11 about rates of mental illness, for example?

12 A. No, it's -- there's a big gap between those  
13 two. Certainly if you read any of the national  
14 literature, you know that mental health problems are  
15 extremely prevalent, and substance abuse problems.  
16 The most common treatment for those, you know, has  
17 been medications and counseling and other therapies;  
18 not inpatient treatment. That's kind of the final  
19 resort when the other community based-type services,  
20 out-patient-type services, aren't available or can't  
21 meet the need. So inpatient treatment represents a  
22 very small percentage of all the treatment for mental  
23 health problems.

24 Q. You heard Dr. Jessee this morning tell us that  
25 they've touched 40,000 people in the last year; right?

1 A. Right.

2 Q. And that's, I take it, many more people than  
3 are put in the psychiatric wards of hospitals; right?

4 A. Yes.

5 Q. And, in fact -- let me ask this. Is it a  
6 desirable thing to -- I mean, from a health planning  
7 perspective, do we want to increase the number of  
8 people who are locked into psychiatric wards of  
9 hospitals?

10 A. It certainly would not be the desired goal I  
11 think of any health planning person.

12 Q. What about in terms of non-psychiatric  
13 hospitalization? Is the philosophy in health planning  
14 in this country that we need more hospitalization and  
15 more hospital beds?

16 A. Well, again, I've been through the whole cycle  
17 with acute care from the late '70s on, and I think  
18 we're all aware that we have in that time consistently  
19 been closing acute care beds. We started in 1974 with  
20 the national health planning guidelines that said four  
21 beds per 1,000 people. And, you know, that just  
22 sounds ridiculous today. We're probably down around  
23 maybe one bed per 1,000 or 1.5 beds per 1,000. I  
24 haven't checked it recently. But, you know, nobody  
25 would postulate that number of beds today. Everything

1 has been -- the trajectory is to replace the inpatient  
2 surgeries, inpatient medical treatment, with  
3 out-patient alternatives, because the infection rates  
4 are lower, the quality of care has been documented to  
5 be just as high, the costs are lower, people are  
6 happier, for a whole lot of reasons. And, in fact,  
7 there was -- yesterday I noticed the USA Today had a  
8 front page article that is based on a new report from  
9 the Journal of the American Medical Association, a  
10 study of Medicare patients from 1999 to I think 2013  
11 which showed that we have dramatically reduced  
12 mortality of the Medicare population. At the same  
13 time we have been reducing hospital beds. And I think  
14 that should -- that philosophy is analogous in the  
15 psychiatric field. The goal should not be to build  
16 more inpatient beds but try to prevent the need and  
17 substitute better community distributed services.

18 Q. As a health planner, do you assume that most  
19 people, if they're able to be treated successfully at  
20 a CSU or by out-patient therapy or by medication would  
21 prefer that to being locked in a psychiatric hospital?

22 A. I think it's safe to say that that's true.

23 Q. And if we look at -- I'm going to hand you a  
24 document I've marked as Exhibit 388, and I'll  
25 represent that this is from Mr. Sullivan's report, the

1 attachments to his report in this case, stuff that he  
2 looked at. Does this give us some indication of the  
3 relative use of inpatient hospitalization versus other  
4 types of treatment for psychiatric patients?

5 A. It does. And the colors represent the type of  
6 mental illness or the level of mental illness; so the  
7 blue is no mental illness, which I think is rather  
8 extraordinary that you have something labeled no  
9 mental illness and yet you've got people getting  
10 mental health treatment. But, anyway, mental health  
11 illness with mild impairment, moderate impairment or  
12 serious impairment. And you can see that there is  
13 much less volume going into that inpatient than into  
14 the other prescription or out-patient-type treatments.

15 Q. And even among people with serious mental  
16 illness, most of them are not getting locked up in  
17 psychiatric wards; right?

18 A. That's correct.

19 Q. Now, is it a reliable methodology,  
20 Dr. Collier, to take overall -- I'm sorry, Your Honor.  
21 I would like to move that as an exhibit, please. 388,  
22 I believe.

23 THE COURT: On the sheet it says 388.

24 MR. JACKSON: Thank you.

25 THE COURT: Exhibit 388 is the next

1 marked exhibit, which is a document that was attached  
2 to Dr. Sullivan's report as Exhibit 24-A.

3 (Marked Exhibit No. 388.)

4 BY MR. JACKSON:

5 Q. Dr. Collier, you were here when Mr. Sullivan  
6 was testifying about overall rates of mental illness  
7 and what percentage of those go untreated; right?

8 A. That's correct.

9 Q. In your opinion, is it a reliable methodology  
10 to take statistics about overall rates of mental  
11 illness and whether or not they're being treated and  
12 try to generate the need for inpatient psychiatric  
13 beds?

14 A. Well, I would say it's certainly an  
15 over-reaching assumption. It doesn't mean -- the fact  
16 that they're not treated doesn't mean that the  
17 appropriate treatment is to institutionalize them.  
18 The appropriate treatment might be medication or  
19 therapy of some other out-patient type.

20 Q. Did you also look at the utilization -- let's  
21 pull up 16. Did you also look at the use rate?  
22 Again, this is a way to measure how many people in  
23 these counties are being put into a psychiatric  
24 hospital; is that right?

25 A. That's correct.

1 Q. Or psychiatric bed, I should say?

2 A. They're getting -- this one is based on the  
3 joint annual report. Exhibit 16, let me double check  
4 that for a second just to make sure.

5 Q. Take your time. For purposes of our record,  
6 we're referring to Exhibit 16 to your report, which is  
7 marked for our proceeding as Exhibit 381.

8 A. Yes. The source is on the printed page, but  
9 it's not on the slide; so I just wanted to double  
10 check. It is the joint annual reports. This is for  
11 those hospitals that reported psychiatric discharges;  
12 so this includes not just psychiatric hospitals but  
13 other medical surgical hospitals that would have  
14 psychiatric beds.

15 Q. These are based on the DRG data; is that  
16 right?

17 A. It's based on what the hospitals report as  
18 psychiatric, substance abuse discharges.

19 Q. First of all, what does this show us with  
20 respect to both the Tennessee psychiatric discharge  
21 rate and the psychiatric discharge rate in the  
22 counties of Tennessee that we're here about?

23 A. It indicates that the top two there, Sullivan  
24 and Hawkins, would be the Tennessee portion of the  
25 defined service area of SBH. And you can see there

1 that Sullivan is well above the state rate. Hawkins,  
2 which is right next to it, is not quite as high.  
3 Together the combined rate of that population is over  
4 the statewide rate. For Washington County, again,  
5 it's higher than the Tennessee rate. When you look at  
6 the additional Tennessee counties that I've proposed  
7 for the alternate service area, combine that area,  
8 again it is above the Tennessee rate.

9 Overall, again, the rate would be 983  
10 discharges per 100,000 population in the alternate  
11 service area Tennessee portion compared to the  
12 statewide rate of 938.6. So, again, above the  
13 statewide rate. It would indicate to me that there is  
14 no obvious access problem here.

15 Q. What about the suggestion that we heard from  
16 Mr. Sullivan that we should aspire to increase the  
17 utilization of inpatient service for psychiatric  
18 treatment in these other counties and bring them up to  
19 the level of Washington County? Is that a sound  
20 health planning principle, in your opinion?

21 A. No. Again, there may be instances where if  
22 you see a much lower use rate that you might look for  
23 an access problem. But just because -- there will  
24 always be one rate amongst a group of counties, just  
25 arithmetically there's going to be one rate that's

1 higher than others. And if you have a state, the same  
2 thing is true, there are going to be counties that are  
3 higher than the state average and counties that are  
4 lower; so if you were several standard deviations away  
5 below the state rate you might look for an access  
6 problem.

7 But here again, there's nothing here. You've  
8 got Unicoi which had the highest rate in 2012. Well,  
9 there's no service in Unicoi, there's no inpatient  
10 service in Unicoi; so there's nothing here that would  
11 indicate to me an access problem. And there is no  
12 indication or evidence that Mr. Sullivan provided that  
13 the Tennessee statewide rate is not an appropriate  
14 rate.

15 Q. And, in fact, Takoma is located in Greene  
16 County and the use rate is lower; right?

17 A. That's correct.

18 Q. And, Dr. Collier, in looking through -- we  
19 won't take the time to make them all exhibits -- but  
20 looking through the materials that Mr. Sullivan  
21 attached to his report, did you see any evidence that  
22 Tennessee's use rate is low or out of whack with the  
23 national average?

24 A. No. It seems to be kind of in the middle of  
25 the range, middle of the pack.

1 Q. And in terms of overall psychiatric beds, if I  
2 may hand you something I've marked as Exhibit 385 also  
3 from Mr. Sullivan's Exhibit 24-A to his report. This  
4 is a ranging of beds, private psychiatric beds per  
5 100,000 of the various states; is that right?

6 A. That's correct.

7 Q. And how does Tennessee come out in comparison  
8 with the national average in this table from the  
9 appendicis to Mr. Sullivan's report?

10 A. Well, for the US on the first page on the far  
11 right it shows 22.9 beds per 100,000 adults. And on  
12 the second page for Tennessee it shows 32.7 beds per  
13 100,000 adults. Again, this is in private hospitals.

14 Q. Which that is above the national average; is  
15 that right?

16 A. Yes.

17 Q. And it's actually above the standard of the  
18 State Health Plan, true?

19 A. Yes.

20 Q. And this again is only private hospitals? It  
21 doesn't include any public hospital beds; is that  
22 right?

23 A. That's correct.

24 Q. Does this suggest to you that there is a  
25 crisis in Tennessee where we're lacking private

1 hospital beds?

2 A. No.

3 MR. JACKSON: Your Honor, I would move  
4 that into evidence, please, as 385.

5 THE COURT: 385 will be marked as the  
6 next exhibit, which is shown as Exhibit 24-A from the  
7 Sullivan expert report.

8 BY MR. JACKSON:

9 Q. Dr. Collier, how does charity care factor into  
10 a need analysis?

11 A. Well, obviously there is a standard in the  
12 rules for looking at the service provided to  
13 underserved population, including TennCare and  
14 indigent and charity population; so it's important in  
15 that regard. It's important from the standpoint of  
16 Woodridge because they are the safety net hospital in  
17 northeastern Tennessee for the indigent patients.

18 Q. You saw that the applicant has projected a  
19 five percent of their patient volumes would be charity  
20 care?

21 A. That's correct.

22 Q. Have you seen any evidence to support that  
23 number or claim?

24 A. None.

25 Q. Mr. Shaheen, you were here when he gave

1 testimony as well; right?

2 A. I was.

3 Q. And you heard he gave numbers of various five  
4 to ten percent or other charity numbers that he threw  
5 out there from some of their other facilities; do you  
6 remember that?

7 A. Yes.

8 Q. Have you seen in the discovery documents  
9 produced by SBH any precise number as to how many  
10 charity patients they've actually been treating?

11 A. No. And that's one of the items that I  
12 requested, the Butler Snow representatives to put in  
13 the discovery requests, the charity and indigent  
14 experience. All that we got back was a payor mix  
15 overall that did not break out charity and indigent.  
16 It had a category of self-pay and then it had a  
17 category -- and that was I think 1.2 percent, and a  
18 category of uncompensated care that was, as I recall,  
19 4.5 percent and had in parentheses that that included  
20 bad debt administrative write-offs. I want to get the  
21 exact wording here since I cited it in my report.

22 Q. Denials?

23 A. Denials. And I think it's clear that denials  
24 and bad debt are not appropriately categorized as  
25 charity care. The administrative adjustments were not

1 defined or explained in any way that you could  
2 categorize those as charity or indigent. And the  
3 self-pay of 1.2 percent in another part of the  
4 interrogatory responses, they pretty much equate  
5 self-pay to indigent care; so if that's true then the  
6 1.2 percent would not be equal to five percent. So  
7 there was nothing in those responses that would  
8 indicate five percent as being reliable.

9 We also tried to get information on existing  
10 SBH facilities. I was able to get some information  
11 for the North Carolina facilities from their license  
12 renewal applications. And for their payor mix that  
13 they reported they had zero for the indigent charity  
14 line. And the only other information that I've seen  
15 again was the audit report which indicated that their  
16 total cost of providing charity care to patients for  
17 SBH was \$491,000 in the last fiscal year 2014, I  
18 believe it was.

19 Q. And that would account for what, in terms of  
20 percentages of their total costs?

21 A. As best I could estimate, given the  
22 information that we have from them, which is sparse,  
23 it would be about half of a percent of their  
24 discharges.

25 Q. Using that metric, can you come up with some

1 rough number of how many people we might be talking  
2 about?

3 A. Given the length of stay that they say  
4 company-wide for self-pay patients, it worked out to  
5 be about 150 patients corporate-wide.

6 Q. That's in all their -- how many hospitals is  
7 that?

8 A. Seven or eight I think in 2014.

9 Q. With how many beds?

10 A. 710 I believe is what we heard.

11 Q. Is it also part of the analysis that you do  
12 for need, important to take into account the effect a  
13 project might have on state appropriation? Is that  
14 part of the activity supported by state  
15 appropriations?

16 A. There is a specific criteria that speaks to  
17 that.

18 Q. Does that apply in this case; in your opinion?

19 A. I think it does because those -- the state  
20 grant represents money that was appropriated by the  
21 state for care at Woodridge that's taking the place of  
22 the state mental hospital for a certain portion of the  
23 population in northeastern Tennessee.

24 Q. Did Mr. Sullivan take into account state  
25 appropriations? the effect this might have on state

1 appropriations in Tennessee?

2 A. He said it didn't apply in this case. But in  
3 another case that he worked on he said that it even  
4 applied to TennCare patients.

5 Q. What case is that that you're referring to?

6 A. That would be the Huntington case.

7 Q. So in the Huntington case Mr. Sullivan  
8 assessed the impact on TennCare patients under that  
9 prong of the rules?

10 A. Yes, I believe that's correct in the report.

11 Q. But in this case he said not applicable; is  
12 that right?

13 A. That's correct. Certainly if it's applicable  
14 for TennCare patients, it would also be applicable to  
15 Woodridge, which these TennCare patients as well as  
16 the state grant patients.

17 Q. Looking at all the factors that we've talked  
18 about, Dr. Collier, the service area and the State  
19 Health Plan and these other specific criteria and  
20 factors. Do you have an opinion as to whether there  
21 is a need for a new 72-bed hospital in Kingsport,  
22 Tennessee?

23 A. I believe my opinion is that there is not a  
24 need for this project in Kingsport.

25 Q. And is that opinion to a reasonable degree of

1 professional certainty?

2 A. Yes.

3 Q. All right. Let's move on then to the next of  
4 the three criteria that you've looked at on economic  
5 feasibility. What were you able to assess about the  
6 economic feasibility of this project?

7 A. Well, I think there are two points. One is  
8 that the applicant did not look at the appropriate  
9 service area. Consequently, it did not look at the  
10 appropriate socio-demographics and population density  
11 and all of those things that should have been  
12 addressed.

13 Consequently, the utilization projection has  
14 no basis if the underlying population and service area  
15 is not appropriate. And if the utilization projection  
16 has no basis, then the financial projection has no  
17 basis and there's no ability to assess the feasibility  
18 of the project. There's no documentation to use to  
19 assess it. Since there was no clear foundation laid,  
20 I would say that you can't really assess the  
21 feasibility.

22 And the applicant said that the basis -- the  
23 second point I would like to make is the applicant  
24 said the basis for the utilization projection is just  
25 their experience in ramping up these projects. In

1 other words, they would have made the same utilization  
2 projection whether they used the large service area,  
3 the small service area, Mobile, Alabama; Green Bay,  
4 Wisconsin, it's just their utilization projection that  
5 they used. And as a health planner, that makes no  
6 sense to me to try to support your project without  
7 looking at the specifics of the population at hand and  
8 the needs and the use rates and all of those things.

9 Q. Did you see any indication that the folks at  
10 SBH had considered any alternatives to meeting  
11 whatever need there may be in the community other than  
12 building a 72-bed hospital?

13 A. I didn't see evidence that there had been an  
14 investigation of other alternatives. Most strikingly,  
15 if you look at the SBH facilities, and I've looked at  
16 all their websites for all the facilities that are out  
17 there, you're struck with the fact that they do a lot  
18 of residential treatment facilities for child and  
19 adolescents. And to me it would seem like that could  
20 have been an appropriate type of project, and I  
21 wondered why they didn't consider an alternative that  
22 included residential treatment facilities and then a  
23 small child and adolescent psych-acute facility, which  
24 is basically what they have in Raleigh, what they have  
25 in Wilmington, you know, other places; so that's one

1 that I know that they are experienced and they do.

2 But it doesn't appear that they looked at that as an  
3 alternative in this case.

4 Q. And, in fact, the 72 beds that they proposed,  
5 that's another one of those things they just have a  
6 plan on the shelf, whether it's for Green Bay or  
7 Mobile or Kingsport; right?

8 A. That's my understanding of the testimony and  
9 what I saw in looking at the other facilities.

10 Q. You mentioned Wilmington. And I should have  
11 probably exhibited this earlier when we were talking  
12 about service area, but let me hand you Exhibit 318.  
13 What is this document, Dr. Collier?

14 A. This is one of the license renewal  
15 applications for the Wilmington facility in North  
16 Carolina that's owned by SBH.

17 Q. And what kind of facility is that? What is  
18 the nature of the treatment that's offered there?

19 A. It's my understanding, as I recall, this is  
20 again a combination. It has a separate residential  
21 section, child and adolescent, and it has a small  
22 acute child and adolescent section, about 20 beds, as  
23 I recall, and 52 beds residential.

24 Q. What information, if any, did this document  
25 that we've marked as Exhibit 318 give you about the

1 service area being served by these child and  
2 adolescent beds operated by SBH in Wilmington?

3 A. Well, it also has a patient origin section  
4 just like the Tennessee joint annual report has,  
5 page 9. And what I concluded from looking at this is  
6 that, as I would suspect, they have a very large  
7 service area. They're located -- well, New Hanover is  
8 the county that Wilmington is located in. I think the  
9 facility is actually in the adjacent county.

10 Wilmington is the largest population base in the area.  
11 That's where they draw more patients. The most  
12 patients come from the Wilmington County, New Hanover.  
13 But if you look at a map of North Carolina you see  
14 that -- well, you don't even have to have a map to see  
15 that they draw from a large number of counties. And  
16 if you did have the map and if you took 90 percent,  
17 you would find that it's a large area and includes all  
18 the surrounding counties.

19 Q. Would the service area of that Wilmington SBH  
20 child and adolescent unit look more like your proposed  
21 service area or more like the applicant's proposed  
22 service area?

23 A. It would definitely be broader, more like my  
24 service area. And the same is true of the Raleigh  
25 facility as well.

1 MR. JACKSON: Your Honor, we would ask  
2 that 318 be introduced.

3 THE COURT: The next marked exhibit will  
4 be Exhibit 318. It is a 2015 mental health substance  
5 abuse hospital license renewal application for  
6 SBH-Wilmington.

7 (Marked Exhibit No. 318.)

8 BY MR. JACKSON:

9 Q. Dr. Collier, to sum up on the economic  
10 feasibility analysis, in your opinion, has this  
11 applicant set forth sufficient evidence that this  
12 project is economically feasible as proposed?

13 A. No, it has not.

14 Q. The final issue that you have looked at in  
15 your report is whether or not the project contributes  
16 to the orderly development of adequate and effective  
17 healthcare facilities; is that right?

18 A. Yes.

19 Q. And how did you go about in doing this  
20 analysis? And you might go to 21. I've put up  
21 Exhibit 21 to your report that we've marked as  
22 Exhibit 381. Does this summarize one step in your  
23 analysis?

24 A. Yes, and it is a key part of the impact  
25 analysis. Looking at the impact of this proposed

1 project on the Woodridge volume of cases, because as I  
2 said early on, Woodridge relies heavily on cases from  
3 this area. So on Exhibit 21 you have on the left side  
4 the payors. And I looked at it from the standpoint of  
5 impact by payor for two reasons: One, the payor  
6 impact is key if, as I believe, there will be a  
7 disproportionate pull away from Woodridge of the  
8 commercial patients. And, secondly, because the  
9 applicant did not provide any information on the  
10 county patient origin. So whereas typically you might  
11 see a layout of so many cases from each county and  
12 look at the county market share to drive impact here,  
13 we didn't have that information; so what I looked at  
14 was cases by payor.

15 So SBH had projected its payor mix of cases,  
16 well, of charges by payor, and that's presented here  
17 under SBH projected payor mix. They projected  
18 20 percent Medicare, 38 percent TennCare, 35 percent  
19 commercial, 5 percent indigent or self-pay, and 2  
20 percent other. I translated those numbers into cases,  
21 because they never gave a case number by payor. But I  
22 used what they provided for their average length of  
23 stay by payor to get a projected year two cases. I  
24 based this on year two because they did not project a  
25 year three volume; so they only had first and second

1 year volume. Year two they're projecting 65 percent  
2 occupancy; so we know that they expect higher  
3 occupancy in the third year, but that was not  
4 provided.

5 The next column in green is Woodridge's  
6 historical market share of that payor type. In their  
7 service area on this chart there are two colored  
8 sections, the green, or blue, I think the print copy  
9 looks blue, and that is based on an analysis of their  
10 proposed service area. The yellow or peach color is  
11 the alternate service area; so I did the same analysis  
12 but with the two different population bases. If you  
13 do the analysis on their service area you come to a  
14 number of cases taken from Woodridge of 1,084. If you  
15 look at the broader service area, the cases taken  
16 would be 1,185 cases taken from Woodridge. That  
17 volume impact sets a range I think to look at, but  
18 it's a conservative range, again, because it's only  
19 based on the second year occupancy of Woodridge. If  
20 we had had a third year, their volume would have been  
21 higher and, consequently, the numbers would have been  
22 higher here.

23 From that point, the next step is to convert  
24 that into a financial impact or range of impact. And  
25 to do that I looked at Woodridge data from their cost

1 accounting system from 2014, which was the most recent  
2 fiscal year data that I had available. I came up with  
3 a set of scenarios that's on Exhibit 24. And this is  
4 the very last exhibit here.

5 Q. And just for our record, Dr. Collier, and to  
6 give His Honor a chance to find it, it's Exhibit 24 to  
7 Exhibit 381, which is your report; is that right?

8 A. That's right.

9 Q. So tell us what this shows.

10 A. Well, again, I'll go through the first  
11 scenario to explain how it's laid out and then explain  
12 the different scenarios. So the first scenario looks  
13 at their proposed service area and their projected  
14 five percent indigent care. So that's sort of giving  
15 them the benefit of the doubt and saying, okay, that's  
16 their service area, that's their payor mix that  
17 they're going to have, and that is the 1,084 cases.

18 The next column is the calculation of the  
19 contribution per case for each payor class using cost  
20 accounting data from Woodridge where I made a judgment  
21 about the fixed and variable components of those costs  
22 and to define contribution per case. That is an  
23 industry definition of that is the net revenue that  
24 you were paid per case minus your variable cost to  
25 produce that product or to treat that case. So it

1 is -- variable cost is the cost that could potentially  
2 fluctuate with volume.

3           So let's say, for example here, the Medicare  
4 contribution per case is \$2,328. That means that  
5 after Medicare payments are received and after you've  
6 paid your variable costs, you know, the actual  
7 staffing that could vary, the supplies that would vary  
8 with that volume, you would have \$2,328 left to cover  
9 all of your fixed costs. Multiplying that times the  
10 volume of cases that would be lost gives a lost  
11 contribution margin of \$265,344. You can see that  
12 varies significantly by payor. For TennCare, the  
13 contribution is \$891. The indigent presented is a  
14 negative number here, and I intentionally did not  
15 include the grant dollars here, because I wanted to  
16 sort of keep this picture clean from that perspective.  
17 And I'll explain that in a moment. But setting aside  
18 any grant money that Woodridge might receive from the  
19 State Mental Health Department, there would be a  
20 negative contribution margin of \$1,331 per case. So  
21 overall the contribution margin for all the cases was  
22 \$1,395 which, again, extrapolated by 1,084 cases gives  
23 \$1.5 million loss.

24           Now the reason I did the negative on the  
25 indigent is, let's assume for a moment, we know that

1 there is testimony that Woodridge does not get paid  
2 for every indigent case they have; so to the extent  
3 that SBH takes 99 cases, and those are cases that  
4 Woodridge didn't get paid for, they were, let's say,  
5 cases on the margin after Woodridge's dollars ran out,  
6 then that would actually be a positive benefit to  
7 Woodridge. So it's kind of a worst-case scenario from  
8 Woodridge's standpoint, I mean, or unlikely scenario  
9 that they would only take those marginal cases that  
10 got no payment; so it's trying to give SBH the benefit  
11 of the doubt here that they get those cases and that  
12 those cases are cases that would not have received any  
13 payment at Woodridge; so that actually reduces the  
14 lost contribution margin; so at a minimum we've got  
15 1.5 million.

16 The second scenario still assumes the SBH  
17 service area, but it assumes no indigent care at SBH.  
18 And in that case, the lost contribution margin is  
19 1.7 million. The other two scenarios are based on the  
20 alternate service area and either five percent  
21 indigent care or zero percent indigent care; so in the  
22 event that what I've said about the alternate service  
23 area is correct and that SBH does target the  
24 commercial insured cases and doesn't do five percent  
25 indigent, then the contribution lost at Woodridge

1 would be 1.9 million, again, assuming 65 percent  
2 occupancy at an SBH facility.

3 Q. And just so we're clear, Dr. Collier, the  
4 impact you've set out in Exhibit 24 to your report,  
5 that's Exhibit 381, this is for one year only; is that  
6 correct?

7 A. That's correct. Obviously the impact  
8 accumulates over time.

9 Q. And as the patient volumes at SBH-Kingsport  
10 increased the impact, you would expect to increase as  
11 well, right?

12 A. Yes, that's certainly likely.

13 Q. Does Exhibit 24 to your report set out your  
14 best professional opinion as to the range of possible  
15 impacts from this project on Woodridge?

16 A. Yes.

17 Q. What does this -- how does this fit into the  
18 orderly development criteria? And what's the  
19 conclusion you draw from looking at this impact and  
20 looking at this marketplace as a whole in the role  
21 that Woodridge is playing in it?

22 A. Well, I think that it would not contribute to  
23 the orderly development in that there is not a  
24 foundation for the need, that there is an access  
25 problem that would in any way outweigh the negative

1 impact on the public safety net that's provided by  
2 Woodridge.

3 Q. Dr. Collier, in the area of housekeeping,  
4 there is one exhibit I forgot to make when you were  
5 talking about the service area. And I would like to  
6 show you Exhibit 323. What does this show?

7 A. There are two pages. The first page is total  
8 population by zip code for the proposed service area  
9 and then including down into Washington County. You  
10 can see that, again, where the population is located  
11 relative to the proposed site. And the second page  
12 looks at population density; so the first page is just  
13 the total population by zip code.

14 You can see, again, the Tri-Cities is where  
15 the population is located. And the next page on the  
16 population density, you see that in this density is  
17 population per square mile. And, remember, the  
18 population density was a specific criterion to be  
19 looked at and it -- I don't recall that it was looked  
20 at in the application. But the population density,  
21 interestingly, is in a corridor that runs, again,  
22 almost directly from Woodridge to the proposed site up  
23 through Washington County; so that's really where the  
24 population has been. And there is a significant  
25 population, a dense population, that's right near the

1 border between Sullivan and Washington, some of which  
2 could probably access the Kingsport area just as quick  
3 or quicker than they could access Woodridge; so once  
4 again, it suggests that to exclude Washington County  
5 from an analysis for this project does not make sense.

6 MR. JACKSON: Thank you, Dr. Collier.  
7 That's all I have. I do want to move that into  
8 evidence, Your Honor.

9 THE COURT: The next marked exhibit is  
10 Exhibit 323, which contains 2014 population by zip  
11 code and population density for the proposed service  
12 area in Washington County.

13 MR. WEST: Your Honor, please, it's  
14 approaching noon and I have some significant amount of  
15 questions for Ms. Collier. I would propose that we  
16 break for lunch and then resume at an appropriate time  
17 and we'll go forward.

18 THE COURT: All right. We've been going  
19 for quite a while also, so it's a good time to take  
20 our lunch break; so we will go ahead and do that and  
21 come back at one o'clock.

22 (Luncheon recess observed.)

23 THE COURT: Mr. West, are you ready to  
24 proceed with your cross-examination?

25 MR. WEST: I believe so, Your Honor.

CROSS-EXAMINATION

1  
2 BY MR. WEST:

3 Q. Good afternoon, Dr. Collier.

4 A. Yes, sir.

5 Q. You and I met, whenever it was, about ten days  
6 ago when I took your deposition; so we've spoken  
7 before. I wanted to ask you some questions at the  
8 beginning of my examination here related to charity  
9 care. What is your understanding of the definition of  
10 charity care for a hospital?

11 A. Well, there are statements by the Health Care  
12 Financial Management Association, the financial  
13 accounting standards forwards definitions of charity  
14 care that most nonprofit hospitals follow in their  
15 accounting practices. Typically, in my experience,  
16 indigent care is defined relative to the poverty  
17 guidelines, may vary state to state as to what the  
18 target hurdle is, and charity care may be more  
19 flexible in that it can refer to people who may have  
20 some form of insurance but whose coverage or whose  
21 medical costs are overwhelming and, you know, the  
22 family could not afford to make the payment even  
23 though they may have some coverage or some assets that  
24 would make them above the guidelines for indigent  
25 care.

1 Q. All right. But how is the concept of charity  
2 care as it's utilized in Tennessee, especially on the  
3 joint annual reports for hospitals, how is that  
4 defined? You know, there's a line item within the  
5 joint annual report that addresses charity care.

6 A. Right. I don't recall what the instructions  
7 are that would go with that.

8 Q. In the course -- well, first of all, I want to  
9 back up a second and ask you something related to your  
10 earlier testimony. In this particular case, you were  
11 hired by Mountain States Health Alliance?

12 A. I believe that's who is signing the checks.  
13 My contact has been with Woodridge.

14 Q. With Woodridge directly?

15 A. Well, I guess staff that are also Mountain  
16 States.

17 Q. When did you commence work in this case?

18 A. It was late September or early October, I  
19 believe.

20 Q. And as I understand your testimony, you  
21 assisted your esteemed lawyers here in developing the  
22 discovery requests that were served on us, on  
23 SBH-Kingsport. I wanted to ask you, have you reviewed  
24 all of the discovery responses from Woodridge back to  
25 SBH-Kingsport's attorneys?

1 A. I have looked at those at some point. My eyes  
2 have passed over them at some point, but I must say  
3 there were thousands of pages.

4 Q. That's one thing we can all agree on. You  
5 will note -- you will recall that in one of the last  
6 later batches of discovery flowing back, documents  
7 flowing back to Strategic from Mountain States, they  
8 provided SBH-Kingsport's attorneys with copies of 2014  
9 joint annual report for Woodridge?

10 A. Yes, sir.

11 MR. WEST: Your Honor, I don't believe  
12 this has been previously marked as an exhibit, but  
13 certainly I wanted to ask Dr. Collier about it.

14 BY MR. WEST:

15 Q. Dr. Collier, I'll represent to you that this  
16 is what we received. It bears a MSHA document number  
17 commencing at 1643; is that right?

18 A. Yes.

19 Q. So is this document I just gave you a  
20 statistics joint annual reports for hospitals for  
21 Woodridge Psychiatric Hospital for 2014?

22 A. Yes.

23 Q. And who signed it on behalf of Woodridge?

24 A. I can't read the first -- it's Lindy White.

25 Q. Lindy White. And what is her position within

1 Mountain States Health Alliance?

2 A. Well, it's signed here as CEO.

3 Q. But within Mountain States Health Alliance,  
4 what roles does she fulfill?

5 A. I don't recall.

6 Q. If you will look on page 18, the number at the  
7 bottom of this page 18 is MSHA Document 1660?

8 A. Yes, sir.

9 Q. And near the bottom of the page there's a  
10 space for the entry of a number for total charity  
11 care; do you see that?

12 A. Yes.

13 Q. And what's the total that's given there?

14 A. \$14,494,304.

15 Q. And this figure on this report is actually on  
16 the page which -- let me back up and let me rephrase  
17 that. Does this figure represent the charges for  
18 charity care?

19 A. Yes, I believe so.

20 Q. All right. And there's been discussion, I  
21 think you even testified on it to some extent,  
22 conceptually there's actually a difference between the  
23 charges for charity care and the cost of charity care;  
24 is that correct?

25 A. That's correct.

1 Q. And what are the costs of charity care?

2 A. Well, I think on the SBH audit, for example,  
3 it's derived based on the ratio of cost to charges; so  
4 it's tied back to the charges ultimately.

5 Q. But it's less than the charges generally,  
6 isn't it?

7 A. Yes.

8 Q. And Mountain States follows the similar  
9 approach in their own finances; don't they? Don't  
10 they in their financial statements have a place where  
11 they state how much the cost of charity care for any  
12 particular year is?

13 A. I don't recall that note, but that's very  
14 common.

15 Q. So for a nonprofit hospital that would be very  
16 common given the accounting standards, HFMA standards  
17 you referenced earlier?

18 A. Yes.

19 Q. And that number would also be -- the number  
20 for the cost to Mountain States of charity care would  
21 also be lower than the charges Mountain States would  
22 have generated for those patients were it to bill  
23 them?

24 A. Yes, typically.

25 Q. All right. So in reality, within the context

1 of this analysis charity care that's listed as  
2 revenue -- actually you could sort of say it's  
3 foregone revenue because it didn't get paid for; is  
4 that right? It didn't get paid for those charges?

5 A. Correct.

6 MR. WEST: Your Honor, I would like to  
7 make this the next exhibit, if I may.

8 THE COURT: The next exhibit will be  
9 marked as 250, and it has been identified as the joint  
10 annual report for 2014 for Woodridge.

11 (Marked Exhibit No. 250.)

12 BY MR. WEST:

13 Q. Dr. Collier, I wanted to ask you some related  
14 questions about the history of charity care at  
15 Woodridge, if I may. So I'm going to provide you with  
16 a document that has not previously been marked as an  
17 exhibit, but it is a public record. It is the joint  
18 annual report of hospitals for 2010 for Woodridge and  
19 ask if that is what it appears to be.

20 A. That's what it appears to be.

21 Q. All right. And if you'll look on page 18 of  
22 this document, I wanted to ask you, down at the bottom  
23 of the page, a similar question to the one I just  
24 asked you about 2014. What is the total charity care  
25 figure given on page 18 of this document for

1 Woodridge?

2 A. It says \$85,221.

3 Q. So then if you look at the top of the page for  
4 the dates covered from 7/1/2009 to 6/30/2010?

5 A. Correct.

6 MR. WEST: Your Honor, if I may, I would  
7 like to make this the next exhibit.

8 THE COURT: The next exhibit will be  
9 marked as 251. It identifies the joint annual report  
10 for Woodridge for the year of 2010.

11 BY MR. WEST:

12 Q. Dr. Collier, if I may, let me return you to  
13 page 18 of this document Exhibit 251. And you'll note  
14 on this page, page 18 of 251, that the first column  
15 results in the middle of the page in a grand total of  
16 gross patient charges?

17 A. Yes.

18 Q. And what is that number for this year? this  
19 fiscal year?

20 A. \$40,546,334.

21 Q. And I'm going to ask you to calculate what  
22 percentage of \$40,546,334 is 85,221. And I can  
23 provide you with a calculator if you want.

24 A. No, I have mine. I don't travel without it.

25 Q. I've gotten to that point myself.

1 A. So you want the charity related to the total  
2 charges?

3 Q. Yes, the percentage of total charges.

4 A. .2 percent.

5 Q. So it's not 2 percent; it's .2 percent?

6 A. Correct.

7 Q. So less than half a percent?

8 A. Correct. Of total charges.

9 Q. Thank you. You can return that document to  
10 the court reporter. Dr. Collier, I've got one more  
11 document in this line of questioning in terms of  
12 Woodridge's charity care history. I want to hand you  
13 a document that is a public document that appears to  
14 be this joint annual report for 2011 for Woodridge and  
15 ask you if you can confirm that's what that is.

16 A. That's what it appears to be.

17 Q. Okay. You have no reason to think that this  
18 one didn't come off the State website?

19 A. No, I don't.

20 Q. I'll represent to you that it did. If you  
21 look on page 18 again, and tell the court what year  
22 this -- what the dates are that are covered by this  
23 report.

24 A. This is from July of 2010 through June of  
25 2011.

1 Q. So the fiscal year, I think that Mountain  
2 States or Woodridge would call that FY 2011?

3 A. Correct.

4 Q. And what's the total of charity care on  
5 page 18 for this report?

6 A. \$85,618.

7 Q. So as a percentage of the -- what are the  
8 gross charges shown on this page?

9 A. \$41,777,009.

10 Q. And so as a percentage of gross charges,  
11 charity care for this year would be roughly similar to  
12 2010 for Woodridge; is that correct?

13 A. Yes.

14 Q. As a percentage?

15 A. Yes.

16 MR. WEST: Your Honor, I would like to  
17 make this the next exhibit, if I may.

18 THE COURT: The next exhibit will be  
19 marked Exhibit 252. It's the joint annual report for  
20 Woodridge for the year 2011.

21 (Marked Exhibit No. 252.)

22 BY MR. WEST:

23 Q. My next exhibit I wanted to ask you about,  
24 Dr. Collier, is fortunately much shorter. I'm going  
25 to hand you a document. If I may approach the

1 witness, Your Honor. I'll ask you if you can identify  
2 that.

3 A. This is from the documents produced by  
4 Mountain States, originally MSHA 874.

5 Q. All right. And I believe, although I can't  
6 recall the precise exhibit, I believe Mr. Sullivan  
7 referenced this in one of his exhibit lists; do you  
8 recall that?

9 A. No, not really, sir.

10 Q. Okay. But if you'll turn to the first page  
11 after the cover sheet, which gives the document  
12 number. I wanted to ask you if this document, which  
13 is an MSHA document for Woodridge Psychiatric  
14 Hospital, covers the actual financial results. It's  
15 kind of an overall view, from fiscal year of 2011 for  
16 Woodridge to fiscal year 2014 for Woodridge?

17 A. Yes.

18 Q. And, similarly, for budgetary analysis, this  
19 covers the fiscal year 2012 budget through the fiscal  
20 year 2013 budget; is that correct?

21 A. Yes, that's what's on here.

22 Q. So you can compare kind of the years across  
23 four years of results and three years of budgets using  
24 this document; is that correct?

25 A. Yes.

1 Q. And if you'll look at the charity self-pay  
2 line on the actual results for those four years, I'm  
3 going to read what I think is the entry for each of  
4 those lines and ask if that's correct. For fiscal  
5 year 2011, the charity and self-pay together were 1.3  
6 percent of revenues?

7 A. Correct.

8 Q. And for 2012 the charity and self-pay together  
9 were 4 percent?

10 A. Yes.

11 Q. And for 2013 the actual numbers, the charity  
12 and self-pay revenues were .7 percent?

13 A. Yes.

14 Q. And then 2014 the charity and self-pay  
15 revenues were 23.9 percent?

16 A. Yes.

17 Q. And if you go to the budget side, in other  
18 words, what Woodridge budgeted for three years, 2012,  
19 2013, 2014. I'll read those again just to speed  
20 things up. The charity 2012 budget as a percentage of  
21 revenues was set at 1.3 percent?

22 A. Yes.

23 Q. And for 2013 was set at 2.8 percent?

24 A. Yes.

25 Q. And for 2014 it was set at .7 percent?

1 A. Yes.

2 Q. And this document actually gives a lot more  
3 information, such as the average daily census over  
4 those four years: 2011 through 2014?

5 A. It does.

6 Q. It shows a steady increase in average daily  
7 census across those four years?

8 A. It has increased, yes.

9 Q. And the same is true for patient days and  
10 admissions?

11 A. Correct.

12 Q. If you look at the next page -- let me just  
13 again to speed things up, this shows more detailed  
14 data about, for example, inpatient and out-patient  
15 revenue and gross revenue and those types of things  
16 across those four years: '11 through '14; is that  
17 correct?

18 A. Yes.

19 Q. All right. And, again, it shows a similar set  
20 of three years of budgetary information on the  
21 right-hand side?

22 A. Correct.

23 Q. And the total operating revenue, like a third  
24 of the way down the page appears to increase every  
25 year from 2011 to 2014?

1 A. Yes.

2 Q. And, actually, in 2014 is approximately -- my  
3 quick arithmetic -- about 3.2 million higher than the  
4 operating revenue was in 2011?

5 A. It is.

6 Q. And, similarly, at the bottom of the page --  
7 what I've asked you I think in your deposition to  
8 define, EBITDA, earning before interest, taxes,  
9 depreciation and amortization, if I'm not mistaken,  
10 goes from about 1.3 million in 2011, falls  
11 significantly the next two years and then rises back  
12 to about 1.5 million, 1.6 million in 2014; is that  
13 correct?

14 A. Correct.

15 MR. WEST: Your Honor, if I may, I would  
16 like to make this the next exhibit in this matter.

17 THE COURT: The next exhibit is  
18 Exhibit 253. Those are documents Woodridge years 2011  
19 through 2014; financial information in 2012  
20 through 2014, budgetary information.

21 (Marked Exhibit No. 253.)

22 BY MR. WEST:

23 Q. While we're on the subject of -- excuse me.  
24 Dr. Collier, you have seen the various documents that  
25 have flowed back and forth between the attorneys as we

1 have prepared for trial for each side?

2 A. I've seen a lot of them. I don't know if I've  
3 seen all of them.

4 Q. Okay. I wanted to show you now one that has  
5 been marked Exhibit 214 in our pretrial exchanges and  
6 ask you some questions about it.

7 Dr. Collier, you have had an opportunity to  
8 examine the document. The front sheet that bears the  
9 exhibit tag, what does it say the document is?

10 A. Mountain States fiscal year 2015 third quarter  
11 ending March 31, 2015, quarterly financial information  
12 and historical maximum annual debt service coverage  
13 ratios, consolidated and unaudited.

14 Q. Dr. Collier, it appears to me -- let me ask  
15 you this: Is it true that this document covers or  
16 provides financial information for Mountain States  
17 Health Alliance itself for the first nine months of  
18 fiscal year 2015?

19 A. That's what it says it is, yes.

20 Q. All right. And there's a balance sheet on the  
21 first page after the title page, and then the third  
22 page of the document after the title page and the  
23 balance sheet is actually a statement of revenues and  
24 expenses?

25 A. Yes.

1 Q. And the total revenues for the net patient  
2 service revenue for Mountain States for the first nine  
3 months of 2015 is how much according to this document?

4 A. 740 million.

5 Q. And the total revenue, counting some other  
6 presumably non-patient service revenues, what is the  
7 total revenue gains and support for the first nine  
8 months of 2015?

9 A. 790,883,858.

10 Q. All right. And, similarly, the -- this list  
11 of expenses not only covers such things as salaries  
12 and wages, but it also covers interest and taxes as  
13 well as depreciation and amortization; is that  
14 correct?

15 A. Correct.

16 Q. And after all those expenses are taken out, at  
17 the bottom of this chart, what is the excess of  
18 revenue, gains, and support over expenses and losses?

19 A. 20.8 million.

20 Q. And the final page is -- apparently it looks  
21 to say SA historical maximum annual debt service  
22 coverage chart; is that correct?

23 A. Yes.

24 Q. So what is the income available to Mountain  
25 States for the first nine months -- for the 12 months

1 ending -- this is a slightly different time period.  
2 Twelve months ending March 31, 2015, what is the total  
3 income available for MSHA's debt service?

4 A. It says 161 million.

5 Q. And what is their maximum annual debt service  
6 as given on this chart?

7 A. 67.2 million.

8 Q. So there's a division of one into the other  
9 that gives you a debt service coverage ratio?

10 A. Yes, of 2.4.

11 Q. All right.

12 MR. WEST: I would like to make this  
13 document, which has been premarked Exhibit 214, I  
14 would like to move it into the record, Your Honor.

15 THE COURT: Exhibit 214 will be marked  
16 Mountain States fiscal year 2015, third quarter ending  
17 March 31st, 2015, quarterly financial information and  
18 historical maximum annual debt service coverage ratio,  
19 consolidated and audited.

20 (Marked Exhibit No. 214.)

21 BY MR. WEST:

22 Q. All right. Next, Dr. Collier, I want to show  
23 you a document that has been premarked Exhibit 219 and  
24 ask if you can read it and just identify it or state  
25 what it says it is, what that document is.

1 A. It says Mountain States Health Alliance  
2 management discussion for the quarter ended March 31,  
3 2015, and nine months fiscal year to date 2015.

4 Q. And if you'll take a moment to look at it,  
5 I'll ask you a couple of questions about it.

6 A. All right.

7 Q. It's true, isn't it, that this document on its  
8 face states that it compares the quarter ending  
9 March 31, 2015, with a quarter ending March 31, 2014?

10 A. Yes.

11 Q. So they set forth various data in here, and  
12 most of them are improvements in data for Mountain  
13 States; is that correct?

14 A. That appears to be true. Most of them are  
15 increases.

16 Q. Yes. That was my point. And for the fiscal  
17 year year-to-date, which is this quarter and the two  
18 previous quarters, similarly, most of the results  
19 cited are positive; is that correct?

20 A. Yes.

21 Q. If you'll look on the final page, page 3, at  
22 the bottom of that, the last text on that chart, on  
23 that page. There's a chart that compares year-to-date  
24 2015 to year-to-date 2014 in terms of the payor mix  
25 presumably for all of Mountain States, I assume; is

1 that correct?

2 A. It looks that way, yes.

3 Q. And does that list a charity care item?

4 A. No, it does not specify that.

5 Q. But it does account for 100 percent of  
6 revenues?

7 A. Yes.

8 Q. And so it has self-pay, for example, for FY  
9 2015 year-to-date self-pay of 7.2 percent of all the  
10 revenues?

11 A. Correct.

12 MR. WEST: Your Honor, if I may, I would  
13 like to move Exhibit 219 into evidence.

14 (Marked Exhibit No. 219.)

15 THE COURT: The next exhibit will be  
16 marked Exhibit 219. It has been identified as  
17 Mountain States management discussion quarter ended  
18 March 31st, 2015, in nine months fiscal year-to-date  
19 2015.

20 BY MR. WEST:

21 Q. Dr. Collier, as I understand it, you testified  
22 that you became engaged in this case in approximately  
23 November or October of 2014?

24 A. September or October, yes.

25 Q. And when did -- what was the first time that

1 you heard anything about an adolescent crisis  
2 stabilization unit being a possibility in Washington  
3 County, Tennessee?

4 A. I don't recall.

5 Q. Had you heard it before you generated your  
6 report?

7 A. Yes.

8 Q. Can you recall what stage of the case you were  
9 working on when you heard it?

10 A. No, I don't. It was -- I think the first I  
11 heard about it was in a conversation with Mr. Jackson.

12 Q. And when was that; do you recall?

13 A. No, it was -- it was well before my report.

14 Q. All right. But had discovery gone back and  
15 forth before you heard about it?

16 A. I don't recall what stage of discovery we were  
17 in at the time.

18 Q. Okay. In your testimony today, you in  
19 response to Mr. Jackson's questions, I know you had  
20 criticisms of -- you expressed criticisms of the  
21 SBH-Kingsport, LLC, defined service area, and you  
22 yourself derived an alternate service area for the  
23 project?

24 A. Correct.

25 Q. But would the presence -- let me backtrack a

1 little bit and rephrase a little bit. Under your  
2 analysis, according to the State Health Plan, in other  
3 words, the 30 beds per 100,000, and regardless of  
4 which service area the SBH-Kingsport or the  
5 alternative one, would the opening of an adolescent  
6 crisis stabilization unit affect your bed need  
7 calculation under the State Health Plan?

8 A. As far as doing the calculations, no.

9 Q. Because the State Health Plan does not address  
10 CSUs per se; does it?

11 A. No, they would not be covered, just like the  
12 substance treatment facilities like Magnolia Ridge are  
13 not considered.

14 Q. And would -- when Frontier goes -- assuming  
15 they go forward with this project, they won't need to  
16 obtain a Certificate of Need; will they?

17 A. I believe that that's correct.

18 Q. And so there's -- other than the -- well, what  
19 has prevented Frontier or Mountain States or anyone  
20 else from already developing an adolescent CSU or any  
21 other type of CSU?

22 A. I'm not able to answer that.

23 Q. You have been here during the testimony, as  
24 Mr. Sullivan has, as experts in this case, and you saw  
25 yesterday where Mr. Jackson examined Mr. Sullivan

1 about a 2007 case arising out of Overton County called  
2 the Livingston Regional Medical Center case?

3 A. Yes.

4 Q. And you've seen the document that he asked  
5 Mr. Sullivan about?

6 A. Yes.

7 Q. Do you know who was the prevailing party in  
8 that case?

9 A. I don't think I know that. I don't recall  
10 that.

11 Q. But that is ascertainable data, for example,  
12 if you went on the HSDA website? For example, you  
13 could determine that?

14 A. Yes.

15 Q. You could also determine it since Livingston  
16 Regional Medical Center in Overton County was the  
17 applicant; is that correct? Mr. Sullivan's client was  
18 attempting to prevent?

19 A. Yes, he was opposing.

20 Q. Right. So if Livingston Regional Medical  
21 Center entered into the general psychiatric business,  
22 then it would show up on their joint annual report; is  
23 that right?

24 A. Yes, I would assume so if they were still in  
25 that business, yes.

1 Q. Let me show you a joint annual report pulled  
2 from the State website, health department website.  
3 You have to go past the first page, of course, but  
4 does this appear to be the joint annual report for  
5 Livingston Regional Hospital for 2013?

6 A. Yes.

7 MR. JACKSON: Your Honor, please, may I  
8 just interpose an objection to the relevance of this.  
9 The point of the cross-examination of Mr. Sullivan was  
10 not what happened in the case, it was that he was  
11 advocating a position in that case which was  
12 360 degrees at odds -- I'm sorry, 180 degrees at odds  
13 position in this case, which is that you shouldn't  
14 look at stuff outside the service area in Livingston.  
15 He looked at stuff, not only Dru a bigger service  
16 area, but looked at things outside that service area  
17 as well, the existing provider. So whether or not he  
18 was successful or not in that case is really not a  
19 point; so I just don't think this is relevant.

20 THE COURT: Can we just stipulate what  
21 the outcome of that application was?

22 MR. JACKSON: I'll stipulate that  
23 Mr. Sullivan's analysis was rejected by the judge in  
24 that case.

25 MR. WEST: Your Honor, I would ask that

1 this be admitted because it does have the date of the  
2 initiation of service. Mr. Jackson opened this door  
3 all the way, because he was criticizing Mr. Sullivan's  
4 criticism of the applicant service area. And one of  
5 the issues in this case is can the applicant define  
6 their service area, and does the CON board take the  
7 service area as the applicant submits it. That has an  
8 important bearing, we believe, on just how the State  
9 Health Plan is applied.

10 THE COURT: But ultimately aren't you  
11 using this document to show what was the outcome of  
12 that case?

13 MR. WEST: Yes.

14 THE COURT: Will you stipulate to what  
15 that is and will you announce the stipulation on the  
16 record? what the outcome was?

17 MR. CHRISTOFFERSEN: Your Honor, I was  
18 there for the case and have the order back at the  
19 office if that would help. In that case,  
20 Mr. Sullivan's client or Mr. West's client ended up  
21 losing the case. And Judge Safley ruled that  
22 Livingston Regional Hospital could open the geriatric  
23 psychiatric unit; however, I don't want to read  
24 anything more into it than that without entering it  
25 into the record and letting it speak for itself

1 because it doesn't necessarily say the applicant has  
2 carte blanche to choose their service area. The  
3 reasonableness of the service area is very much at  
4 issue in the case.

5 THE COURT: Well, I'm really just looking  
6 for the ultimate outcome of the case without getting  
7 into the details.

8 MR. WEST: I will accept  
9 Mr. Christoffersen's summary.

10 MR. JACKSON: I will accept it also.

11 MR. WEST: I also concur that one thing  
12 this record does not need is more paper.

13 BY MR. WEST:

14 Q. Dr. Collier, this question has been asked of  
15 Mr. Sullivan; so I have to ask it of you as well for  
16 the record to be more rounded. How much have you been  
17 paid in this matter for your work so far?

18 A. Well, I think my answer at deposition was  
19 about 55 to 59,000, and that was for the June --  
20 through the June billing, and I haven't invoiced  
21 anymore since then.

22 Q. All right.

23 A. So there certainly would be some more for  
24 July, but I have not --

25 Q. Sitting here today?

1 A. That's still all that I've invoiced.

2 Q. And what is your hourly rate?

3 A. \$350 an hour.

4 Q. You have a long history of involvement in  
5 health planning and that type of thing as you've  
6 described in your CV, Dr. Collier. In Tennessee,  
7 particularly since the framework of the CON process  
8 was shifted from the former agency known as the Health  
9 Facilities Commission to the HSDA as it's currently  
10 known, which I believe was approximately 2002, have  
11 you drafted a Certificate of Need application? In  
12 other words, filled out the form and filled it as the  
13 contact person?

14 A. No.

15 Q. And prior to the change, although it wasn't a  
16 major change in the three criteria, for example, had  
17 you ever in Tennessee filled out the CON application  
18 form and filed it as a contact person?

19 A. I don't believe so. If I did it was so far  
20 back it's in deep memory somewhere.

21 Q. It might have been the time when I worked for  
22 them, which I can assure you was a long time ago. You  
23 had mentioned also that you consulted with -- I don't  
24 know whether it was Baptist or Saint Thomas -- but  
25 they jointly acquired Middle Tennessee Medical Center

1 in Murfreesboro?

2 A. Correct.

3 Q. Can you remember when that was?

4 A. I'm thinking in the '90s.

5 Q. And when was the last time that you worked in  
6 any capacity on a psychiatric bed or inpatient  
7 psychiatric bed Certificate of Need application  
8 whether for or against it?

9 A. For a CON application it would have been in  
10 the '90s.

11 Q. And was that in Tennessee?

12 A. No.

13 Q. Now, I know from your testimony and from your  
14 report that you have reviewed and analyzed  
15 Mr. Sullivan's report on our behalf as our expert.  
16 You have done that; right?

17 A. Yes.

18 Q. And I believe that in his report he utilized a  
19 Certificate of Need application of TrustPoint Hospital  
20 in Rutherford County as one of his exhibits?

21 A. He did.

22 Q. And you have not challenged his analysis in  
23 your report or otherwise of TrustPoint Hospital's  
24 choice of just a two-county service area?

25 A. Well, I haven't gone back and reviewed the

1 whole file on TrustPoint. I do know that in the  
2 section that he included, it included some of the  
3 argument that they made, one point of which was that  
4 there were people in their service area who were more  
5 than an hour away from services; so they seemed to  
6 also use the one-hour travel time as an access  
7 argument as to why the existing providers were not  
8 accessible to their service area.

9 Q. Do you know the driving time required to go  
10 from Murfreesboro to Franklin? In other words, to go  
11 from Rutherford County to Williamson County?

12 A. I've made that trek, but I would hesitate  
13 without double checking because I haven't made it  
14 recently.

15 Q. And certainly if you were in western  
16 Rutherford County, you would be pretty close to the  
17 Williamson County line; is that right?

18 A. Some people would be, yeah.

19 Q. Well, my question really was: You have not  
20 and do not now challenge Mr. Sullivan's statement in  
21 his report that they had a two-county service area for  
22 TrustPoint that the application specified?

23 A. No, I believe that's what they used.

24 Q. And, similarly, do you know whether Rolling  
25 Hills, which is the psych hospital in Williamson

1 County, do you know if their service area that they  
2 had claimed included Rutherford and Bedford County?

3 A. I don't recall.

4 Q. Well, it was more than two counties; wasn't  
5 it?

6 A. I just don't remember.

7 Q. Okay. Dr. Collier, do you still have your  
8 report in front of you?

9 A. I do.

10 Q. I was looking on pages 2 and 3 of your report.  
11 And you can turn to those? I want to ask you some  
12 questions about it.

13 A. Okay.

14 Q. The text that you set forth on these two  
15 pages, that text is actually drawn from the HSDA  
16 rules; is that correct?

17 A. Correct. Everything in the bold print.

18 Q. Yes, that's correct. There's some that's not  
19 bold. And also the text at the bottom of page 2  
20 and -- I may have misspoken. You actually have  
21 portions of the State Health Plan set forth on these  
22 pages; is that also correct?

23 A. Yes.

24 Q. So the three sort of regulatory components in  
25 the Tennessee CON process, you have the statute which

1 has the three criteria?

2 A. Correct.

3 Q. And then you have the State Health Plan or the  
4 Guidelines for Growth? I think this portion is still  
5 considered the Guidelines for Growth. And then you  
6 have the rules of the HSDA itself; is that correct?

7 A. Yes.

8 Q. And under your interpretation, for example, on  
9 page 2, your interpretation of the rules that are set  
10 forth there, would you draw from the section of the  
11 HSDA rules, is it your interpretation under 1.C. that  
12 the reference to -- well, it says, "Existing or  
13 certified services or institutions in the area"; is  
14 that correct? Is that what it says?

15 A. Yes.

16 Q. And your interpretation of the term "in the  
17 area," is not a reference to a service area chosen by  
18 the applicant?

19 A. Well, the language doesn't say service area.  
20 The next one it does say service area.

21 Q. Other than that, is there anything else that  
22 gives you guidance as to whether the expression in the  
23 area is broader than the service area?

24 A. No.

25 Q. And, similarly, if you go on page 3 under B

1 for service area under the guidelines for growth text  
2 that you've included, B.1. refers to the geographic  
3 service area. It says, if I may read it, "The  
4 geographical service area should be reasonable based  
5 on an optimal balance between population density and  
6 service proximity for the community service agency,"  
7 which I don't think, that's not in the quote, but I  
8 don't think the community service agencies really  
9 exist for this purpose; do they?

10 A. Not that I'm aware of.

11 Q. So from your report, it appears that the  
12 service proximity expression, quote, "service  
13 proximity," that is in there, you read that as  
14 extending service proximity beyond the service area?

15 A. I think it could be reasonable to consider  
16 beyond the immediate boundaries if it's very proximal.

17 Q. But it's also reasonable not to; isn't it?

18 A. It doesn't preclude you from that reading.

19 Q. And B.2. also refers to the service area  
20 itself; is that correct?

21 A. Yes.

22 Q. And C.3. has been a subject of some discussion  
23 in your report and in your examination today. This is  
24 the provision of the State Health Plan, actually I  
25 believe that states, and this is a quote, "The impact

1 of the proposal in similar services supported by State  
2 appropriations should be assessed and considered," end  
3 of quote. That's what it says; is that correct?

4 A. Yes.

5 Q. And once again, what is your interpretation of  
6 that section, that particular provision, of the State  
7 Health Plan as it applies to this case?

8 A. Well, I thought that it was reasonable to look  
9 at that provision as it relates to the State grant  
10 funding at Woodridge for indigent patients.

11 Q. And I think we've seen the -- we have in the  
12 record the actual grant contract that you're referring  
13 to, I believe, at least up to 2014, Ms. Bailey I  
14 believe testified to that; isn't that right?

15 A. Yes.

16 Q. And who is that contract between?

17 A. It's the Department of Mental Health &  
18 Substance Abuse Services, I believe, and Mountain  
19 States.

20 Q. And so it's not directly with Woodridge; is  
21 it?

22 A. No, it's not.

23 Q. And it's not a direct appropriation from the  
24 General Assembly of Tennessee to Woodridge either; is  
25 it?

1 A. It is not.

2 Q. So in your analysis of the impact of the  
3 proposal on similar services that are supported by  
4 State appropriations, did you look at the impact of  
5 the SBH-Kingsport CON application on Mountain States  
6 itself?

7 A. Well, the contribution margin impact is on  
8 Woodridge and thus on Mountain States.

9 Q. Excuse me. I'm sorry.

10 A. As part of Mountain States.

11 Q. You've seen from the exhibits that we've  
12 introduced just in your cross-examination today that  
13 Mountain States itself has a very large amount of  
14 revenue. It has significant costs, but it also has  
15 large amounts of revenue; is that correct?

16 A. The numbers are big on both sides.

17 Q. Right. And it has sufficient debt coverage.  
18 It's at a 2.4 debt coverage ratio at least as of the  
19 end of March of this year?

20 A. It appears so. I'm not sure what their debt  
21 service coverage requirements are under their bond  
22 documents.

23 Q. I think that was covered in the report. It  
24 says approximately 68, 69 million.

25 A. But I'm saying that usually in your bond

1 documents it states a coverage ratio that you must  
2 maintain.

3 Q. Have you looked at ratings of all the Mountain  
4 States's bonds?

5 A. No, I have not.

6 Q. Have you looked at the ratings of any of them?

7 A. Yes. The ones that were part of the exhibits  
8 to Mr. Sullivan's report, I believe was a large  
9 portion of their bond.

10 Q. Well, how much bonded indebtedness does  
11 Mountain States have?

12 A. It's over a billion dollars. That's billion  
13 with a B.

14 Q. And how many bond issues comprise that?

15 A. I don't recall.

16 Q. But it's more than just one or two, isn't it?

17 A. Yes, it's several.

18 Q. And also there are other rating agencies such  
19 as Fitch's; aren't there?

20 A. Yes, there are.

21 Q. And Standard and Poor?

22 A. Yes.

23 Q. Did you look to see how Fitch's or Standard  
24 and Poor rated those Mountain States or any of those  
25 other bond issues?

1 A. I don't believe so.

2 Q. You did reference one, I believe it was  
3 Moody's report or something in your report?

4 A. Yes.

5 Q. There are other bond rating agencies; aren't  
6 there?

7 A. There are.

8 Q. In a similar vein, we've heard testimony that  
9 Woodridge is a department of Johnson City Medical  
10 Center. You were here for that testimony, I believe?

11 A. Yes.

12 Q. Did you assess the impact, even the negative  
13 impact, that you projected in Exhibit 24 of your  
14 report? Did you assess in your analysis the impact  
15 that you set forth in Exhibit 24 on Johnson City  
16 Medical Center?

17 A. Not separate from this amount, which is in  
18 part of Johnson City Medical Center for purposes of  
19 Medicare reporting. It would be a department of  
20 Johnson City Medical Center.

21 Q. Well, also -- we covered this in your  
22 deposition, and I think Woodridge does not dispute, it  
23 is a satellite of Johnson City Medical Center?

24 A. Correct.

25 Q. And Medicare imposes certain requirements,

1 what they claim to be satellites of hospitals?

2 A. That's correct.

3 Q. For example, they have to be under the same  
4 license? And that's true for Woodridge and Johnson  
5 City Medical Center; is that correct?

6 A. That's my understanding.

7 Q. And they have to be held out to the public as  
8 a satellite larger institution; is that also correct?

9 A. Again, I did not go back and review those  
10 requirements.

11 Q. You have no reason to dispute that?

12 A. No, I don't.

13 Q. And, similarly, you have no reason or basis to  
14 dispute the assertion by SBH-Kingsport, LLC, that as a  
15 satellite of Johnson City Medical Center, Woodridge  
16 and Johnson City Medical Center by Medicare  
17 regulations have to share expenses and revenues?

18 A. There are certain things they have to share,  
19 yes.

20 Q. So you don't dispute that statement that they  
21 have to share expenses and revenues?

22 A. I'm not sure if they have to share all  
23 expenses and all revenues. There may be some other  
24 entity out there that I'm not aware of that's in the  
25 mix.

1 Q. But you would agree there are regulations  
2 under the Medicare regulations that address these  
3 issues?

4 A. Yes.

5 MR. WEST: Your Honor, if I can take just  
6 a moment.

7 BY MR. WEST:

8 Q. Dr. Collier, you will recall, it seemed like  
9 longer ago, but a few days ago I took your deposition?

10 A. Yes, a couple of weeks.

11 Q. A couple of weeks. Thank you. And at your  
12 deposition we made Collier Exhibit 83. I'll ask you  
13 can you identify that as Collier Exhibit 83?

14 A. Yes, it's the joint annual report of hospitals  
15 for Johnson City Medical Center for 2013.

16 Q. And if you will look on page 19 of this  
17 document, Exhibit 83, please, ma'am. Do you have  
18 that?

19 A. Yes, I do.

20 Q. On page 19 of Exhibit 83 refers to the  
21 financial data for Johnson City Medical Center?

22 A. Yes.

23 Q. So on the left-hand side, what is the total  
24 revenue given for Johnson City Medical Center for its  
25 fiscal year 2013?

1 A. 407.2 million.

2 Q. And what are the total expenses given for  
3 Johnson City Medical Center in 2015?

4 A. 376.8 million.

5 Q. And that's approximately a 30 to \$31 million  
6 difference. It may be simple arithmetic to determine  
7 how much the revenue exceeded the expenses?

8 A. Yes.

9 Q. So it had at least 30 million more in revenue  
10 than it had in expenses; is that correct?

11 A. Yes, based on this.

12 Q. And the expense figure given of roughly 376.8  
13 million, that's after the overhead allocation of  
14 36.2 million is included in expenses; isn't that  
15 correct?

16 A. Correct.

17 MR. WEST: Your Honor, I would like to  
18 make Exhibit 83, I would like to move it into the  
19 record as been previously marked.

20 THE COURT: Exhibit 83 will be marked the  
21 Department of Health Joint Annual Report of Hospitals  
22 for 2013 for Johnson City Medical Center.

23 (Marked Exhibit No. 83.)

24 BY MR. WEST:

25 Q. Dr. Collier, you were here this morning for

1 Dr. Jesse's testimony?

2 A. Yes, sir.

3 Q. And in describing the -- I guess another way  
4 to use an expression is the service area for Frontier  
5 Health, for example, where Frontier Health has  
6 services. Dr. Jessee did say that it covered Wise,  
7 Scott, and Lee counties in Virginia; is that correct?

8 A. I don't remember specifically, but he showed a  
9 lot of facilities and a lot of counties including up  
10 into Virginia.

11 Q. But you have no reason to dispute that if he  
12 said that in the transcript that's what he meant?

13 A. I assume he did.

14 Q. I wanted to address some issues in your report  
15 briefly, if I may. In your discussion of the historic  
16 service area for Indian Path Pavilion in Map 3, you  
17 don't include as an identified county Russell County,  
18 Virginia?

19 A. No. As I said, I cut it off at approximately  
20 89 to 90 percent, and Russell County would have been  
21 within 95 percent.

22 Q. I wanted to point out -- I wanted to ask you  
23 one other question about this map. And setting aside  
24 Indian Path's history or whatever, is that once Indian  
25 Path closed as a psychiatric provider, there's only

1 one -- well, you take out Indian Path service area  
2 that you claim, for example, there's only one provider  
3 west of Woodridge in that service area for psychiatric  
4 services; is that correct? that would be Takoma, yes?  
5 Greene County?

6 A. Takoma.

7 Q. And that's on the southern end of the service  
8 area you described on Map 3?

9 A. The southwest end.

10 Q. Southwest. Dr. Collier, in your testimony  
11 this morning, in response to a question from  
12 Mr. Jackson, you had referenced that a -- and I was  
13 taking notes. I'm not sure I got this quite right.  
14 Is it your testimony that a service area should have  
15 -- a primary service area should have 90 to  
16 95 percent, provide 90 to 95 percent of the health  
17 care to some of these patients?

18 A. No, I said the service area. My definition of  
19 service area would account for 90 to 95 percent of the  
20 patients.

21 Q. Would that include the primary service area  
22 and the secondary service area?

23 A. If you were going to divide it into a primary  
24 and secondary, yes.

25 Q. And where would you make the cut off between

1 the primary and the secondary service area?

2 A. That's a matter of judgment. I typically look  
3 at the vast majority could be 60, 75 percent.

4 Q. So, for example, it could be two-thirds of the  
5 patients, for example?

6 A. In some cases you kind of -- you have to look  
7 at how the data fall and see what looks reasonable  
8 within that.

9 Q. So I must have misunderstood you. So you  
10 weren't saying that the primary service area had to  
11 provide 90 to 95 percent of the patients?

12 A. No, I did not.

13 Q. We were discussing just a moment ago your map  
14 of Indian Path Pavilion patients or counties that  
15 provided some of their patients -- I'll get the exact  
16 title. Map 3 is what we were discussing?

17 A. Yes.

18 Q. And, again, that's for the data that you  
19 utilized to compile a map of the information on Map 3?  
20 That's for 2007, 2008, 2009?

21 A. Yes.

22 Q. And Mountain States owned Indian Path Pavilion  
23 at that time; is that correct?

24 A. Yes.

25 Q. And during that time, the volumes were

1 shifting, weren't they? Woodridge was becoming larger  
2 and Indian Path was becoming smaller in utilization  
3 for psychiatric services?

4 A. Well, I know Indian Path was going down. I  
5 don't recall the numbers for Woodridge.

6 MR. WEST: Your Honor, could we take a  
7 short recess at this point? I want to track down a  
8 particular exhibit and then I can finish up fairly  
9 rapidly with Dr. Collier after that.

10 THE COURT: All right. We'll take a  
11 short break.

12 (Recess observed.)

13 MR. WEST: I did locate the exhibit, Your  
14 Honor. It's Exhibit 246. If I may approach the  
15 witness.

16 THE COURT: Has it previously been  
17 marked?

18 MR. WEST: Yes, it's already an exhibit.  
19 And if I may stand next to the witness, it's quicker  
20 than me trying to locate my copy.

21 BY MR. WEST:

22 Q. Dr. Collier, I'll give you a moment to look at  
23 it.

24 A. Okay.

25 Q. Dr. Collier, I've handed you Exhibit 246. And

1 it is a Mountain States' document; is that correct?

2 A. Yes, it appears to be.

3 Q. And I think there is previous discussion about  
4 it that you may have heard testimony about in this  
5 proceeding. And it shows data for I guess the  
6 psychiatric facilities in the area of northeast  
7 Tennessee for 2005 to 2010 or part of 2010; is that  
8 right?

9 A. That's what it's titled, yes.

10 Q. And my question to you before we took the  
11 break for me to locate the exhibit was: In terms of  
12 Indian Path and Woodridge, did not they swap positions  
13 on the chart in terms of who had more admissions over  
14 that time period?

15 A. Well, the 2005 number for Woodridge is  
16 incorrect.

17 Q. Right. But as it proceeds through those five  
18 years, which one has more admissions?

19 A. In 2005 the actual admissions to Woodridge  
20 were 2,600, so they were higher in 2005.

21 Q. But in 2009, for example, which institution,  
22 Indian Path or Woodridge, had more admissions?

23 A. Woodridge was the same and Indian Path was  
24 declining, which is consistent with why Mountain  
25 States would want to consolidate.

1 Q. My question was not the relative growth or  
2 falling. Between the two of them, which had more?

3 A. Well, Woodridge continued to have more  
4 throughout the whole period.

5 Q. And Mountain States owned it beginning of  
6 2005?

7 A. Right. Through this whole period.

8 Q. All right. Thank you. You can hand that back  
9 to the court reporter. You may have this in front of  
10 you, Dr. Collier, 318, something that Mr. Jackson  
11 asked you about. If you'll look at page 5 of the  
12 North Carolina document that's Exhibit 318. Do you  
13 see that?

14 A. I do.

15 Q. The top line says reimbursement source?

16 A. Yes.

17 Q. What is the primary -- what is the main  
18 reimbursement source listed on page 5?

19 A. Medicaid.

20 Q. And between Medicaid and Health Choice and  
21 Medicaid MCO, how many patient days are accountable?  
22 And you can get the calculator.

23 A. 5,963.

24 Q. And that's out of a total of 6,544?

25 A. That's correct.

1 Q. You can pass that back to the court reporter.

2 A. When I saw this, I also noted on this page, by  
3 the way, that a lot of the staffing is listed as  
4 as-needed rather than being paid on-site staff, which  
5 I thought was rather unusual for a psychiatric  
6 facility and seems to contrast with what they say in  
7 this application as far as staffing.

8 Q. And what is the size of this facility that's  
9 on the previous page?

10 A. 72 beds. The acute component is 20 and 52-bed  
11 residential, I believe.

12 Q. Right. And the reimbursement source that's  
13 listed is for psychiatric inpatient; is that correct?  
14 On page 5?

15 A. Yes.

16 Q. And also page 5 refers to the -- over that  
17 table you just cited it says Psychiatric and Substance  
18 Abuse Hospitals as the title; is that correct?

19 A. That's what it says, yes.

20 Q. And the size of the psychiatric hospital  
21 facility is 20 beds?

22 A. The acute side of it, yes.

23 Q. You can return that to the court reporter.

24 Dr. Collier, you have your report in this matter still  
25 in front of you?

1 A. I do.

2 Q. If you would look at Exhibit 9, please, ma'am.  
3 Exhibit 9 to Exhibit 381. Thank you, Mr. Jackson.

4 A. Yes, I'm there.

5 Q. Okay. We're good. On this page there are  
6 essentially -- there's two. There's one table but it  
7 has like two parts. There's the upper part and the  
8 lower part?

9 A. Yes.

10 Q. So the upper part analyzes the bed need for  
11 the SBH service area as chosen by the applicant; is  
12 that correct?

13 A. Correct.

14 Q. So the total adult bed need that you give on  
15 that page, just for the SBH service area, not the  
16 alternate area, is 78 bids; is that also correct?

17 A. Yes, for 2019.

18 Q. 2019, yes. In addition to that, do you  
19 perform a similar analysis in Exhibit 8 of your  
20 report, which is Exhibit 381, for adolescents?

21 A. Yes, I did.

22 Q. And what is the 2009 total bed need for  
23 adolescents? First just the total figure, then  
24 excluding those children four and under.

25 A. The total gross need is 15.9. And then if you

1 exclude the under 5 it's 12.4.

2 Q. So just using the Strategic Behavioral Health,  
3 SBH-Kingsport, service area as denominated by the  
4 applicant. There is a total need, and excluding the  
5 four and under population, there would be a total need  
6 of 90.4 patients, 78 plus 12.4 in 2019?

7 A. Yes. With 12 for the adolescent, 78 for the  
8 adults.

9 Q. So that would be 90.4, but you would need to  
10 deduct the 12 beds at the Bristol Regional Medical  
11 Center to get the total need; is that correct?

12 A. If you limited it to that, yes.

13 Q. So there would be a total need then of a  
14 little over 78 beds in 2019 for that age group we were  
15 discussing, and the applicant proposed to provide 72  
16 beds; is that correct?

17 A. That's correct. And the complement of beds  
18 would not fit because of the 28-bed proposal for child  
19 and adolescent.

20 Q. But the gross bed need formula -- there would  
21 be a need for the gross number of beds; is that  
22 correct?

23 A. There would be a need for 12 child and  
24 adolescent and 66 adult.

25 Q. And how many non-child adolescent beds does

1 SBH-Kingsport propose?

2 A. 72 minus 28, 44.

3 Q. And so 44 is less than 66, if I'm remembering  
4 all the string of numbers. So from that standpoint,  
5 in a gross sense there would be a need for the adult  
6 beds proposed by SBH-Kingsport?

7 A. For the adult beds, yes, if you accepted that  
8 service area.

9 Q. I understand. And the global 30-bed per  
10 100,000 formula does not just by itself deduct out  
11 child and adolescent populations per se? You  
12 individually analyze adolescents and children; is that  
13 correct? as the next step after of the gross bed need  
14 analysis?

15 A. Yes, I segregated the under five, because it's  
16 not part of this application.

17 Q. Right. But does the formula itself tell you  
18 to?

19 A. No, it doesn't tell you to do the 65 and over  
20 either, which I also calculated.

21 Q. Right. Now, in response to your lawyer's  
22 questions, Mr. Jackson, Mr. Sullivan, in analyzing the  
23 appropriateness of the service area, he didn't rely  
24 solely on Indian Path Medical Center or Health South  
25 Rehab in Kingsport; did he?

1 A. In his -- I'm sorry. You said in his  
2 analysis?

3 Q. In his report.

4 A. Oh, I think he had Holston Valley in there.

5 Q. Which is in Kingsport?

6 A. Yes.

7 Q. And did he also have Bristol Regional over on  
8 the other side of the county? The psychiatric  
9 facility in Bristol, Tennessee?

10 A. If you say so. I just didn't that one.

11 Q. But in any event, his report speaks for itself  
12 as does his testimony; is that correct?

13 A. Yes.

14 Q. Mr. Jackson walked you through some analysis  
15 where based on his questions or his questions and your  
16 responses, analogized reductions in acute care. When  
17 I say acute, I mean physical care as opposed to mental  
18 health, acute care facilities to reductions. The  
19 implication that you gave, at least to my  
20 understanding, was because health care on the acute  
21 side may be reducing bed capacity then, therefore,  
22 healthcare on the mental health side should also  
23 reduce bed capacity; is that your view?

24 A. No, I wasn't saying that directly. I was  
25 saying that you can't assume that just because there's

1 a reduction in beds that that is a bad thing. And it  
2 seems strange to me to argue that what I thought I  
3 heard being argued was that we ought to be targeting  
4 higher use rates, hospitalization rates. And that  
5 seems to me not to be the right goal.

6 Q. Do you know of any reason why the utilization  
7 inpatient psychiatric facilities by residents of  
8 Washington County, Tennessee, should be suspect or  
9 receive any criticism of that?

10 A. I don't understand the question.

11 Q. Well, in your report -- and I can't recall the  
12 exact exhibit -- you give use rate analysis?

13 A. Exhibit 16?

14 Q. On page 26 of Exhibit 16 of Exhibit 381. I  
15 think you spoke, you wrote about it at some length and  
16 spoke this morning about it. And if you were to in  
17 2013 sort of stack the counties in terms of their high  
18 to low utilization rates, Washington would be first  
19 followed by Sullivan, and Sullivan would be followed  
20 by the other counties that you list: Washington,  
21 Greene, Carter, and Unicoi?

22 A. If you rank them, yes. And while we're on  
23 that, let me say that I misspoke this morning about  
24 the source on this. I realized at lunch, I looked  
25 back at it, and the State rate is based on the joint

1 annual reports. The individual county rates are based  
2 on the hospital discharge data base.

3 Q. And the hospital discharge data base, is that  
4 the HDDS documents you referred to in your report?

5 A. Yes. So we supplemented that with the JARS  
6 for hospitals that didn't report up through the HDDS.  
7 So this is kind of a combined source document; so I  
8 failed to get that on the source.

9 Q. And the HDDS data source that you refer, is  
10 that also sometimes called the THA data base?

11 A. Yes.

12 Q. Access to that is somewhat limited, isn't it?

13 A. It is.

14 Q. And THA regards it as proprietary information  
15 that only its members can share?

16 A. That's correct. And the members can only  
17 share it with their agents or representatives, I  
18 believe.

19 Q. So Mr. Sullivan couldn't just call the THA and  
20 get access to the database if he were not representing  
21 a hospital?

22 A. That's true, I believe.

23 Q. And my question is -- I'm sorry, I probably  
24 phrased it inarticulately there. Washington's  
25 utilization, for example, is significantly higher than

1 Hawkins in your data for inpatient psych services?

2 A. It is.

3 Q. And my question is, is there any reason to  
4 believe that the utilization rate in Washington County  
5 is suspect for any reason?

6 A. Not that I'm aware of. It's been pretty  
7 consistent. And I will say, too, again, diving deeper  
8 than what's here, which is an overall county use rate.  
9 If you look at the underlying age specific use rate,  
10 Hawkins has the highest child and adolescent discharge  
11 rate of any of these counties, which I think further  
12 supports my view of these as not indicating an access  
13 issue, because there's certainly not a child in an  
14 adolescent facility in Hawkins County. Just generally  
15 the -- you know, given that Unicoi has a high rate in  
16 one year, I think that's indicative of small number  
17 analysis, which I think is the problem with  
18 Mr. Sullivan's report for Huntington. And looking at  
19 Weakley County, his argument was that Weakley County  
20 has a high rate for elderly psychiatric discharges,  
21 and that's an indication that -- and other counties  
22 had low rates. So he believed since there was a  
23 facility in Weakley County that we ought to try to  
24 raise the rates to that level, that that was the  
25 appropriate rate.

1           But Weakley County is a small county like  
2           Unicoi. He relied on one year; it was high. And when  
3           I checked it for the year before and the year after,  
4           it was significantly lower. And that's what happens  
5           when you look at small counties and use rates for one  
6           service in one year. You get significant variations.  
7           But Hawkins has been relatively steady, and there's no  
8           reason to think that there is an anomaly or a problem  
9           on that use rate.

10          Q.           You said Hawkins. Did you mean Washington?

11          A.           Well, I think you asked me about Hawkins.

12          Well, you asked me about both. You asked me about  
13          Washington first and then you asked me about Hawkins.

14          Q.           Well, let me ask it again. The county with  
15          the highest use rate is Washington; is that correct?

16          A.           It wasn't in 2012.

17          Q.           But in 2013 it was?

18          A.           Yes.

19          Q.           And in 2011 it was?

20          A.           Yes.

21          Q.           And in 2013 it only missed being the highest  
22          by -- well, it did miss it some. But my point is,  
23          let's just stick with Washington. My question to you  
24          is: Is there any reason to believe that you know of  
25          that the use rate for Washington County is suspect in

1 the sense that there is some fraud going on or there's  
2 some improper referrals going on or anything like  
3 that?

4 A. Not that I'm aware of.

5 Q. All right. So in the -- were you involved in  
6 the Huntington case?

7 A. Actually that's interesting because I was  
8 asked to be by Mr. Elrod when it was a Butler Snow  
9 case. And I declined to take the case because I  
10 didn't think the application was good. I did not want  
11 to try to rehab it. That's the kind of thing I don't  
12 have to do anymore when I take my cases. That case  
13 was approved, but it was obviously not approved on a  
14 health planning basis by the HSDA review board. And I  
15 told Butler Snow that I didn't want to do it, because  
16 if you looked at it from a health planning perspective  
17 it was not consistent. I didn't think the volume  
18 would be there; so I turned it down. I think the case  
19 was then transferred from Butler Snow because of the  
20 conflict they had, and that's how it got to  
21 Mr. Sullivan.

22 Q. So what you just testified was that the HSDA  
23 made a mistake in that case?

24 A. Yes.

25 Q. All right. But here you think the HSDA was

1 right?

2 A. I am not informed by the HSDA opinion.

3 Q. I know. But you are a health planning expert,  
4 and you just expressed the judgment that the HSDA made  
5 an error in the Huntington case?

6 A. That's correct.

7 Q. So going back to the data at hand, if a rate  
8 of 1,192.7 discharges per 100,000, again, that's a  
9 rate, that doesn't mean if the county has less than  
10 100,000 it's going to have that many discharges; is  
11 that correct?

12 A. Correct.

13 Q. If that rate is not illegitimate or  
14 inappropriate or questionable for inappropriate  
15 referrals or anything else, I believe, and you have no  
16 information that it would be, that's for Washington  
17 County, if it occurred in Hawkins County would that  
18 cause you any concern?

19 A. Well, I'm not sure. That's kind of a strange  
20 hypothetical. That's not the rate in Hawkins County.  
21 If it occurred in one year, it might raise a question  
22 mark. I might investigate and look further. But, I  
23 mean, the populations are different; so they're likely  
24 to have different use rates.

25 Q. But Washington County has different

1 demographics from Hawkins County; is that correct?

2 A. Correct.

3 Q. It's got ETSU there. They're more highly  
4 educated, they're more industrial based, more  
5 commercial based; is that correct? than Hawkins you  
6 would expect?

7 A. Well, I don't know if it's, I mean, if it's --  
8 I don't recall the income levels but, you know, it may  
9 be that there are people commuting living in Hawkins  
10 that are, you know, working in Washington that would  
11 have the same level of education or income or  
12 whatever.

13 Q. Well, why do Washington Countians, based on  
14 your analysis, on a discharge basis utilize inpatient  
15 psychiatric services that would rate higher than  
16 Hawkins County residents?

17 A. Well, you would have to look a lot more  
18 carefully to be able to conclude anything about that.  
19 You know, it could be relative to education levels,  
20 level of marketing of services, physician referrals,  
21 the age distribution of the population. As I said, if  
22 you break this down, you find that Hawkins does have a  
23 high discharge rate for child and adolescent compared  
24 to Washington, but they have a relatively low  
25 discharge rate on the elderly population. So

1 different -- any population, if you looked at medical  
2 surgical use rates or psychiatric use rates, there's  
3 going to be some significant variations.

4 Q. But the difference here though is  
5 approximately 35 to 40 percent; isn't it?

6 A. Not every year.

7 Q. No, but in 2013 it is?

8 A. In 2013 if you looked at one year, yes, it  
9 would be lower. But then it's not unusual to find  
10 that kind of variation.

11 Q. You keep up or have kept up through this case  
12 with changes in or proposed changes in Tennessee's  
13 regulatory structure for psychiatric bed needs;  
14 haven't you?

15 A. I understand that that is being discussed and  
16 that there are -- I've seen one proposed change with  
17 requests for comments.

18 Q. And the one you're talking about is a document  
19 from Mr. Jeff Ockerman's office about a proposal to  
20 raise the bed need formula from 30 beds per 100,000 to  
21 50 beds per 100,000?

22 A. I have seen that, yes.

23 MR. JACKSON: Your Honor, please, I would  
24 object to the relevance of this testimony or evidence.  
25 The proposal that Mr. West is referring to is a

1 proposal that has been made. It's subject to comment  
2 right now. It's in the comment period. There are  
3 going to be comments on it. It hasn't been adopted.  
4 It may or may not be adopted. It's not the State  
5 Health Plan today. It's 30 beds per 100,000 as per  
6 100,000, as we have all heard; so it is both  
7 irrelevant and also misleading to refer to a planning  
8 standard that has been proposed and that has not been  
9 adopted; so I would move that it be excluded and that  
10 the reference to it be stricken.

11 MR. WEST: Your Honor, Mr. Ockerman's  
12 office is a division of the Department of Health. He  
13 is in charge of the state health planning office. And  
14 it seems to me -- I'm not claiming that it is  
15 inactive. If it is a fact that it has been generated  
16 and sent out, and Dr. Collier has testified that it  
17 is, then that's a fact that has -- it is a fact and it  
18 speaks for itself. It's not a final report.

19 THE COURT: How is it relevant to this  
20 matter if it is just a proposal or if it is not  
21 anything that's going to be examined for this case;  
22 correct?

23 MR. WEST: That's correct. But there's  
24 been a lot -- well, there's testimony from  
25 Mr. Sullivan about alternative bed need formulas, and

1 this is one that's under consideration in this state.  
2 It's at least relevant in that sense. It's not  
3 dispositive, but it's at least relevant. I disagree  
4 with my colleague here, and I think her testimony  
5 should be allowed given whatever weight the court  
6 believes it should.

7 THE COURT: Well, I won't necessarily  
8 strike what's been testified to already, because it  
9 goes perhaps to the overall discussion that a number  
10 of the witnesses have had about the current state of  
11 mental healthcare, and this witness has talked about  
12 them, Mr. Sullivan has also. But I don't want to  
13 belabor the point, just the fact that that fits in the  
14 overall scheme. I think we can move on.

15 MR. JACKSON: Thank you, Your Honor.

16 MR. WEST: Thank you. Your Honor, if I  
17 can have just a second, I think I may be --

18 BY MR. WEST:

19 Q. No, before I do, I did want to ask you also,  
20 Dr. Collier, since we're near the end of your report,  
21 if you would look at Exhibit 23, please, ma'am, on  
22 page 33, Exhibit 23 of Exhibit 381.

23 A. Okay.

24 Q. The variable costs per case that you reference  
25 in Exhibit 23 for 2014, I wanted to ask you about the

1 indigent line item there. You list 1,241 cases. And  
2 my first question is: The 1,241, does that include  
3 the grant cases that we've discussed?

4 A. Yes, I believe it does.

5 Q. So the net revenue per grant case as you saw  
6 Ms. Bailey testify about various reports that she has  
7 to fill out, it appears that for many of those cases  
8 the average length of stay was approximately 4.25 days  
9 or so, there's significant revenue at least for  
10 however many it takes till the grant amount for that  
11 month runs out; is that correct?

12 A. Well, again, the grant money is not factored  
13 into this page at all.

14 Q. Well, what would happen if you did?

15 A. Well, your contribution margin per case for  
16 that category of indigent, which includes the grant  
17 patients and may include others as well, would be  
18 positive and probably to the tune of maybe positive  
19 \$800 or so.

20 Q. So you would have a positive contribution  
21 margin for the indigent and grant patient line item of  
22 roughly \$800 per case?

23 A. Yes. That means it would cover the variable  
24 cost, but that doesn't include like the fixed  
25 salaries, nursing administration, all the other fixed

1 expenses of running the facility that would be under  
2 fixed costs.

3 Q. Well, that's also true for all the other  
4 contributions?

5 A. Correct.

6 Q. So you would have a positive contribution of  
7 say roughly \$800, and your TennCare contribution  
8 margin is about 891; is that correct?

9 A. That's correct.

10 Q. So for TennCare, Medicaid and the grant  
11 patients, there's a positive contribution margin of  
12 around \$800 or higher per case at Woodridge in 2014?

13 A. Right. And that would mean that the impact  
14 would be greater than what I've estimated.

15 Q. Right. But the indigent or grant patients  
16 that you're projecting that SBH would take as set  
17 forth in Exhibit 24 is either zero or approximately 99  
18 or 108 patients; is that right?

19 A. That's correct.

20 Q. All right. So you then don't dispute the  
21 grant reports that have been made exhibits in this  
22 case when they speak of revenues for -- Woodridge  
23 receives significant revenues for a lot of those  
24 patients?

25 A. Well, they receive a certain amount that's

1 capped to cover the patients to the extent that they  
2 can.

3 Q. Okay. So it would be \$465, \$475 per day up to  
4 a certain number of days per patient until the grant  
5 funds ran out for that month?

6 A. That's my understanding, yes.

7 Q. And what do you know about whether there are  
8 any months in which grant funds do not run out?

9 A. I'm not aware of any.

10 Q. All right. And you had seen the documents  
11 that, as you testified earlier, flow back and forth  
12 between the SBH-Kingsport's attorneys to Butler Snow  
13 and from Butler Snow back to SBH-Kingsport in this  
14 case?

15 A. Yes. As I said, I think I've seen them all,  
16 but there was a flurry there at the end I'm not sure I  
17 saw.

18 Q. Dr. Collier, I would like to show you a  
19 document that's marked as a Mountain States produced  
20 document starting at 1211 and ask what this document  
21 appears to be.

22 A. It says Woodridge Psychiatric Hospital report.  
23 I think from the testimony it's one of the monthly  
24 reports that they make to the Department of Mental  
25 Health.

1 Q. And this one, the first date of admission  
2 cited in one of the columns about a third of the way  
3 in from the left, the first date of admission is  
4 5/22/14, and the last date of admission is 6/27/14; is  
5 that correct?

6 A. Yes.

7 Q. And if you look at the very last page at the  
8 bottom of the chart, can you read into the record what  
9 those three lines say?

10 A. This one says total dollars remaining first of  
11 month 210,686.67. Total dollars used this month  
12 163,498. Total dollars remaining end of month  
13 47,188.67.

14 Q. So then for this particular month, or it looks  
15 like roughly June 2014, the dollars under the grant  
16 were not exhausted by the end of the month as  
17 reflected in this report?

18 A. Again, that's what it would appear to be.  
19 But, again, I have not worked with this report. I  
20 don't really know exactly how they do this report.

21 Q. But you heard Ms. Bailey's testimony whenever  
22 it was in this hearing?

23 A. Yes.

24 MR. JACKSON: Your Honor, I do think this  
25 is a little unfair. I think Ms. Bailey testified they

1 had to reimburse the State if they didn't use up all  
2 the money. He's suggesting with this line of  
3 questioning that Woodridge keeps the extra money,  
4 which is not just not what the evidence showed through  
5 Ms. Bailey whom we heard from yesterday.

6 MR. WEST: Your Honor, with due respect  
7 to my colleague, I'm not saying anything except  
8 putting this document in the record. Ms. Bailey  
9 accounted for what happened. My point, if there is a  
10 point, is that there are months where it's not used  
11 up.

12 MR. JACKSON: Well, the question should  
13 have been directed to Ms. Bailey about this, not to a  
14 witness who doesn't even know. And Ms. Bailey said  
15 that they didn't get excess money from the State for  
16 these patients.

17 THE COURT: Well, what Ms. Bailey said  
18 speaks for itself. And at this point, Dr. Collier can  
19 testify to it to the best of her ability, and if she  
20 is limited she can say so. She has indicated to some  
21 extent. So how much depth you want to go into it with  
22 her --

23 MR. WEST: I would just like to move it  
24 into the record, Your Honor, as an exhibit.

25 THE COURT: All right. Exhibit 254 will

1 be marked the Woodridge monthly report, and it has  
2 dates May and June of 2014.

3 (Marked Exhibit No. 254.)

4 BY MR. WEST:

5 Q. Dr. Collier, if I may go back on the record.  
6 You have sat through the hearing thus far as an  
7 observer in the audience and you've seen the  
8 introduction of the June 29, 2015, Community Health  
9 Needs Assessment of Indian Path Medical Center?

10 A. Yes.

11 Q. And have you reviewed that document?

12 A. I have looked at it at one point, yes.

13 Q. And you would agree -- would you disagree with  
14 the statement that it indicates it has a page which  
15 sets forth the service area for Indian Path Medical  
16 Center?

17 A. It has that page, yes.

18 Q. And that service area consists for Indian  
19 Path, which is based in Kingsport of Hawkins County,  
20 Tennessee; west Sullivan County, Tennessee; and Scott  
21 and Wise counties?

22 A. That's what it shows, as I can recall.

23 Q. And also you observed or heard the admission  
24 of Exhibit 212, which was a similar June 29, 2015,  
25 Community Health Needs Assessment for Johnson City

1 Medical Center?

2 A. Yes.

3 Q. And in reviewing the service area on page 31  
4 of that document -- and I can show it to you if you  
5 need it, I'm just trying to speed things up here.  
6 That service area for Johnson City Medical Center did  
7 not include Hawkins County, Tennessee, and ends at the  
8 Virginia border?

9 A. I trust you on that.

10 MR. WEST: Your Honor, I'll be happy to  
11 show it to her. I'm just trying to speed things up.  
12 It's Exhibit 212. If I may approach.

13 THE COURT: Mr. Jackson?

14 MR. JACKSON: I have no objection to that  
15 being assumed, if that's what it says.

16 THE WITNESS: Yeah, I trust you.

17 BY MR. WEST:

18 Q. All right. Good. Well, I wanted to ask you a  
19 question. If the Johnson City -- have you been on the  
20 Mountain States website? Have you ever used that?

21 A. I did look at that during the last six months  
22 or seven months or so as I was starting the project.  
23 Not recently.

24 Q. Okay. And assuming that the website does not  
25 have a -- let me rephrase, Your Honor. If Johnson

1 City Medical Center does not claim Hawkins County as a  
2 service area or as being within its service area, then  
3 how can Woodridge claim Hawkins County within its  
4 service area given that Woodridge is a part of Johnson  
5 City Medical Center?

6 A. Well, because it's my understanding that those  
7 service areas are not speaking to psychiatric  
8 services. I would imagine that Mr. Ling could address  
9 that. That is their organizational chart and how they  
10 organize their services and he can speak to that  
11 better than I can.

12 Q. But do you know whether Woodridge publishes  
13 its own 2015 community health needs assessment?

14 A. Not that I'm aware of. I have not seen it.

15 Q. And the function of it -- what is the function  
16 of a community health needs assessment?

17 A. Well, it can have several functions, but part  
18 of it is so the organization can test what community  
19 needs are, health needs and other needs, for the  
20 purpose of its program development or program  
21 assessment, and also to support the mission of the  
22 hospital as well to explain to the community what they  
23 do.

24 Q. Does it have an IRS filing function as well?  
25 Is it referenced in the 990s?

1 A. Well, it is, again, usually part of the 990  
2 submission.

3 Q. To the IRS?

4 A. To the IRS.

5 Q. I wanted to ask you to refer back to your  
6 report, Map 8, of Exhibit 381.

7 A. Okay.

8 Q. And this is a map that you have developed that  
9 shows a map of what you call the alternate service  
10 area for SBH-Kingsport?

11 A. Yes.

12 Q. I have a couple of questions for you. The  
13 inclusion of Russell County in this service area, it  
14 is true, isn't it, that the Clearview Hospital or Unit  
15 up in Russell County is a 20-bed unit?

16 A. I believe so.

17 Q. And there's actually an additional  
18 geropsychiatric unit owned by Mountain States, at  
19 least under development, up in Dickinson County just  
20 to the north of Russell County; isn't that correct?

21 A. Yes. I'm not sure of the stage of that.

22 Q. But it's been addressed in some form or  
23 fashion?

24 A. Yes.

25 Q. So if you're a resident of Russell County,

1 Virginia, and you're planning to come to  
2 SBH-Kingsport, you actually have to leave your home  
3 county, which has 20 beds. You have to drive by or  
4 near Ridgeview, which I think has 28 beds, the 12-bed  
5 units at Wellmont, and then drive over to western  
6 Sullivan County to go to SBH-Kingsport. Is that what  
7 you're saying?

8 A. They could, yes.

9 Q. Well, how else would they get there?

10 A. Well, I'm saying that's true, they could.  
11 They could get there that way, yes.

12 Q. In that sense, is that a very logical  
13 assumption that they would bypass basically 60 psych  
14 beds, if they were from Russell County? They would  
15 leave 20 beds behind when they left, they would pass  
16 by 40 more on the way to Sullivan County. Are the  
17 utilization rates that high up in Russell County?

18 A. Actually I don't know, because that's Virginia  
19 data. But what we do know is that Russell County  
20 patients did go to Indian Path Pavilion. Not large  
21 numbers, but they did in each of those three years  
22 that I looked at.

23 Secondly, you have to consider that the  
24 proposed facility is going to be brand new. It's a  
25 free-standing facility. Thirdly, which I don't think

1 has been talked about at all in this case so far, but  
2 for psychiatric services, people don't necessarily  
3 want to be in their home community. Typically, we  
4 talk about healthcare services you want to be close,  
5 but despite HIPAA, there are still people who are  
6 afraid that everybody in the neighborhood is going to  
7 know if they're in the local psychiatric facility. In  
8 fact, in some of the material that Mr. Sullivan  
9 included about reasons why people don't get  
10 hospitalized for psychiatric services, one of the  
11 reasons frequently cited was they didn't want people  
12 in the community to know.

13           So I don't think it's unreasonable that  
14 Russell County patients could and would, to a certain  
15 degree, be a target market for this facility. Not  
16 that they would be there in large numbers, but I would  
17 still likely find them in the 90 percent, especially  
18 when you consider that this is going to include a  
19 large child and adolescent psychiatric facility. You  
20 know, right now, if this were to be approved, you  
21 know, there's not a child and adolescent facility at  
22 Clearview, Ridgeview, or Wellmont.

23 Q.           But your goal of avoiding the local  
24 acquaintances could also be satisfied by going down  
25 from Russell County to basically Ridgeview or

1 Wellmont, BRMC, just inside of Tennessee, couldn't it?

2 A. That's correct. I said there are several  
3 reasons that could explain someone using that  
4 facility; that's one of them.

5 Q. And isn't the Clearview facility located in  
6 Lebanon, Virginia?

7 A. I believe that's correct.

8 Q. And the other thing you base your premise on  
9 here, on Indian Path Pavilion utilization for certain  
10 years while it was still a psych hospital, the last  
11 three years roughly?

12 A. Yes, I looked at three years.

13 Q. Do you know for sure how many beds were at  
14 Ridgeview and Wellmont during that time period?

15 A. I would have to go back to double check, I'm  
16 not sure. I know Clearview -- I mean, Ridgeview has  
17 reported different bed numbers. Actually, their last  
18 report they reported 32 beds on their cost report.

19 Q. Well, do you know how many they reported in  
20 2008 or 2009?

21 A. No, I don't.

22 Q. So you did not include that in your analysis?

23 A. No.

24 Q. And how about the 12-bed unit at  
25 Wellmont-BRMC? Did you make a historical view of that

1 in terms of what its size of beds were in 2008 or  
2 2009?

3 A. No.

4 Q. One final point on this. And I may have  
5 touched on this earlier, so I apologize. Looking at  
6 this larger map, once again, all of the facilities in  
7 this alternate service area, northeast, east, or  
8 southeast Kingsport by a significant degree? Is that  
9 right? except for Takoma?

10 A. Yes. Except for Takoma.

11 Q. Dr. Collier, the analysis that you just walked  
12 through for personal privacy reasons why people might  
13 want to go far away for psychiatric services, would  
14 that mean also, if that were true, then would people  
15 within Washington County, Tennessee, for example, be  
16 not very likely to go to a psych hospital in  
17 Washington County, Tennessee, would they?

18 A. Well, I didn't say that that's the most  
19 prevalent reason. I'm saying that there are people  
20 for whom that is a motivation. And I think there are  
21 people in Washington County who will travel to  
22 Sullivan County to go to a new facility and also  
23 because it's out of their immediate community.

24 Q. Well, if that were true then, if a new  
25 facility was built in Kingsport, then that wouldn't

1 stop people from Sullivan County. In fact, it would  
2 encourage people from Sullivan County to go down to  
3 Woodridge; wouldn't it?

4 A. Well, again, you're talking about adding a  
5 brand new shiny facility that is going to be marketing  
6 very heavily throughout the region. So you've got I  
7 think a major marketing effort that's going to be very  
8 attractive to a wide range of that area.

9 Q. Didn't you see in the discovery documents that  
10 the Mountain States's Health Alliance staff really  
11 wished that Mountain States Health Alliance would  
12 market Woodridge more heavily? Isn't that in the  
13 process improvement chart that Mr. Sullivan referred  
14 to?

15 A. That was one of the comments, yes.

16 Q. So actually the complaint at Mountain States,  
17 at least from that document, one of them was Mountain  
18 States at that time was not marketing Woodridge much  
19 or not as much as they should?

20 A. That's how I read it.

21 Q. And Ms. Bailey testified that they're doing a  
22 better job of being out in the community and letting  
23 them know their services, right?

24 A. That's correct.

25 Q. And so marketing is not a illegitimate or

1 inappropriate activity for psychiatric hospitals?

2 A. No, it's not.

3 Q. So if SBH-Kingsport fills its hospital, it's  
4 not inappropriate for them to market --

5 A. No. And they'll have to market because  
6 they'll be a new entrant into the market.

7 Q. The other general point I wanted to ask you  
8 about was you've heard Ms. Bailey's testimony and then  
9 seen the numbers. Woodridge is running at above an 85  
10 percent occupancy rate currently, at least this month  
11 is what she testified; is that right?

12 A. Yes.

13 Q. So there isn't much physical room within  
14 Woodridge for additional patients, especially given  
15 the break out of -- the way the facility breaks out;  
16 is that correct?

17 A. That's correct.

18 Q. And Mr. Sullivan's chart that we introduced as  
19 evidence that showed the individual days has taken the  
20 spreadsheet, the flow sheet, census number and looking  
21 at how many beds that completed, that showed a pretty  
22 high -- that showed a very high occupancy rate on many  
23 days; is that correct?

24 A. Yes.

25 Q. And the gentleman from -- Dr. Jessee from

1 Frontier was indicating that he thought there was a  
2 need for an adolescent CSU in Johnson County?

3 A. Yes.

4 Q. And that's never been built anywhere, right?

5 A. You mean Johnson City?

6 Q. I'm sorry. Johnson City. I don't think that  
7 there has been an adolescent CSU in Johnson County,  
8 but in Washington County?

9 A. Yes.

10 Q. And you, yourself, have said there's a need  
11 for at least 30 beds in the broader service area, for  
12 example, 2019?

13 A. Thirty beds, yes.

14 Q. And if you looked at our service area,  
15 SBH-Kingsport's service area as defined in the  
16 application, and did the analysis just on that, you  
17 would see a need for over 70 beds; is that correct?

18 A. Yes, I believe that's correct.

19 Q. All right. You've been around the healthcare  
20 field for a long time and you've seen the changes. Is  
21 one of the major changes that has happened recently  
22 the Affordable Care Act?

23 A. Yes.

24 Q. And doesn't the Affordable Care Act mandate  
25 increased access to health insurance benefits for

1 mental health coverage?

2 A. It did, yes.

3 Q. So is that another reason -- why would that  
4 not result in higher utilization across the board if  
5 insurance coverage for mental healthcare, which  
6 Congress has indicated that it should, why would that  
7 not raise the utilization of psychiatric hospitals or  
8 other types of mental healthcare?

9 A. It may. I mean, we haven't seen the results  
10 yet. It started I think in 2014.

11 Q. Did you account for that in your report?

12 A. As far as -- I'm not sure what you mean.

13 Q. The potential for increased utilization of  
14 inpatient psychiatric facilities?

15 A. No, I did not project or speculate on that  
16 impact.

17 Q. So you didn't mention it?

18 A. No, I don't believe so.

19 Q. And you have heard -- I believe it was  
20 Mr. Sheehan's testimony that SBH has seen that impact  
21 at least starting to show up in their other  
22 facilities?

23 A. I was here for his testimony; yes.

24 Q. And do you have any reason to disagree with  
25 that possibility or that actuality?

1 A. I don't have that information.

2 Q. All right. So if Mr. Shaheen testifies about  
3 it from his personal knowledge, you have no basis on  
4 which to say that he's incorrect?

5 A. No.

6 Q. One other question: On your expanded service  
7 area that's behind you there from Map 8 of your  
8 report, if for whatever reason you excluded Russell  
9 County from your analysis, what would be the impact on  
10 the bed need in that remaining area?

11 A. If you just excluded Russell County?

12 Q. And its population, yes.

13 A. Well, the bed need there would go up.

14 Q. There isn't a whole lot of population. I  
15 mean, there's some population, not a whole lot in  
16 Russell County --

17 A. That's correct.

18 Q. Twenty beds, so you lose a little population,  
19 but you lose a relatively large amount of beds?

20 A. Correct.

21 MR. WEST: Your Honor, may I have just a  
22 moment to consult with Mr. Sullivan and my client?

23 THE COURT: Yes.

24 MR. WEST: Your Honor, I believe that's  
25 all the questions I have on cross-examination for

1 Dr. Collier. Thank you, Dr. Collier.

2 THE WITNESS: Thank you.

3 THE COURT: Redirect?

4 MR. JACKSON: Yes, Your Honor. Just a  
5 few minutes.

6 THE COURT: Would you like to go now,  
7 Mr. Christoffersen?

8 MR. JACKSON: That might make it easier  
9 for --

10 CROSS-EXAMINATION

11 BY MR. CHRISTOFFERSEN:

12 Q. Dr. Collier, you say that the agency got it  
13 wrong in the Baptist Memorial Huntington application?

14 A. That was my judgment when I read them.

15 Q. Okay.

16 A. Initial analysis.

17 Q. Do you know how the Administrative Judge ruled  
18 in that contested case?

19 A. No, I don't.

20 Q. So it would surprise you to know that the  
21 Administrative Judge came to the same conclusion and  
22 approved the application?

23 A. I believe that I did know that it had been  
24 approved, yes.

25 MR. CHRISTOFFERSEN: No further

1 questions.

2 THE COURT: Redirect.

3 REDIRECT EXAMINATION

4 BY MR. JACKSON:

5 Q. Dr. Collier, Mr. West has introduced a  
6 document into our proceedings called Exhibit 211, this  
7 Community Needs Assessment. Do you recall him asking  
8 you some questions about that?

9 A. Yes.

10 Q. And just to speed things along, a Community  
11 Needs Assessment of this sort is a process where  
12 healthcare providers go out to the community and  
13 interview stakeholders and people to see what the  
14 community's needs are; right?

15 A. Correct.

16 Q. And in this case, if I look at page 6 of  
17 Exhibit 211, it says that the folks at Mountain States  
18 talked to Kingsport city schools, United Way of  
19 Greater Kingsport, the Sullivan County Health  
20 Department, the Sullivan County Department of  
21 Education, the Kingsport Chamber of Commerce, the  
22 Kingsport Board of Mayor and Aldermen and Healthy  
23 Kingsport. Does that sound like the kind of people  
24 that healthcare entities go out and interview as part  
25 of these community needs assessments?

1 A. Well, I've done them, and that's kind of the  
2 typical list.

3 Q. And anywhere in this Community Needs  
4 Assessment that was prepared just in 2015 in this  
5 community of Kingsport, Tennessee, was there any  
6 recommendation by anybody that you saw looking at this  
7 that there needed to be a new 72-bed psychiatric  
8 hospital in Kingsport?

9 A. No, there was not.

10 Q. Mr. West asked you some questions about the  
11 TrustPoint application over in Rutherford County. Do  
12 you recall those questions?

13 A. Yes.

14 Q. Is looking at the TrustPoint application for a  
15 hospital in Rutherford County pertinent to you in  
16 coming up with a reasonable service area for this  
17 psychiatric hospital in Sullivan County?

18 A. No.

19 Q. Why not?

20 A. I just think there are different circumstances  
21 involved. I think that one was -- they were giving up  
22 some rehab beds and replacing them with psych beds,  
23 and there was no construction costs involved; so there  
24 were just a lot of differences in them.

25 Q. Are there differences in the demographics of

1 Rutherford County and the demographics of Sullivan  
2 County in terms of population growth?

3 A. Well, Rutherford is one of the fastest growing  
4 and, you know, Sullivan County is basically static or  
5 stable in population.

6 Q. You were asked some questions about primary  
7 versus secondary service areas. And just to be clear,  
8 did the statutes or rules that the agency and the  
9 legislature have adopted, do they use those terms  
10 primary and secondary?

11 A. No, it's just the service area total.

12 Q. Did the applicant in this case identify a  
13 primary and secondary service area in the application?

14 A. No.

15 Q. Did Mr. Sullivan in his report that he  
16 prepared in this case identify a primary and a  
17 secondary service area?

18 A. Well, he used the term primary service area.  
19 But, again, he kept the same service area.

20 Q. And he never identified a secondary service  
21 area and provide any analysis of that; did he?

22 A. That's correct.

23 Q. You have been asked some questions about  
24 Johnson City Medical Center, about all these JRs, and  
25 it has been repeatedly emphasized that Johnson City

1 Medical Center and Woodridge are the same for Medicare  
2 purposes; right?

3 A. Correct.

4 Q. And Exhibit 83 that Mr. West gave you is the  
5 financial statement of Johnson City Medical Center,  
6 and if that medical center's financial statement  
7 indicates that it's Johnson City Medical Center, which  
8 apparently is the party and interest here according to  
9 the applicant, provided \$54 million in charity care in  
10 the year 2013; \$54 million in discounts to uninsured  
11 patients; they had \$40 million of bad debt. Do those  
12 sound like numbers in the ballpark you would expect  
13 given the size of that entity?

14 A. Yes.

15 Q. So it's fair to say, isn't it, that the party  
16 that is here before the court in the form of Mountain  
17 States Health Alliance through Johnson City Medical  
18 Center has provided many tens of millions of dollars  
19 in charity care each year to the residents of this  
20 area; right?

21 A. That's correct.

22 MR. JACKSON: That's all I have.

23 MR. WEST: No questions, Your Honor.

24 THE COURT: All right. You can step  
25 down. Counsel, would you all -- she's got a lot of

1 documents in front of her. Make sure none of those  
2 are actual exhibits. I have her report, the actual  
3 exhibits that I'll pass to the court reporter.

4 MR. JACKSON: I think, Your Honor, I gave  
5 her an extra set so I wouldn't be walking back and  
6 forth, but I'll make sure.

7 THE COURT: And take them back so they  
8 are not there for the next witness to. Mr. West, you  
9 gave her some also, so maybe you can go through them  
10 with Mr. Jackson.

11 MR. WEST: I'll look through them with  
12 Mr. Jackson.

13 THE COURT: You can step down.

14 THE WITNESS: Thank you.

15 (Off the record.)

16 THE COURT: All right. Would you like to  
17 call your next witness?

18 MR. SWEARINGEN: Mountain States calls  
19 Dr. Harsh Trivedi.

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HARSH K. TRIVEDI,

was called as a witness, and after having been first  
duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. SWEARINGEN:

Q. Dr. Trivedi, could you please state your full  
name for the record?

A. My name is Dr. Harsh, H-A-R-S-H, K. Trivedi,  
T-R-I-V-E-D-I.

Q. And, Dr. Trivedi, if you could, there's no  
microphones in this room, so speak up as loud as you  
comfortably can. Drink your water as necessary.

A. I will.

Q. What is your current occupation and job title?

A. I'm a physician. In terms of job title -- I  
apologize for Vanderbilt's many titles -- I have three  
different roles. The first is Executive Director and  
Chief Medical Officer for Vanderbilt Behavioral  
Health. The second is Vice Chair for Clinical  
Affairs, Department of Psychiatry.

THE COURT: I want to get these down; so  
if you can slow down just a minute.

THE WITNESS: Sure.

THE COURT: Executive Director for  
Vanderbilt Behavioral Health?

1 THE WITNESS: Executive Director and  
2 Chief Medical Officer for Vanderbilt Behavioral  
3 Health. The second role is Vice Chair for Clinical  
4 Affairs at the Vanderbilt University Department of  
5 Psychiatry. And the third role is Regional Chief  
6 Medical Officer for the Vanderbilt Health Affiliated  
7 Network.

8 MR. SWEARINGEN: Permission to approach,  
9 Your Honor?

10 THE COURT: Certainly.

11 BY MR. SWEARINGEN:

12 Q. Dr. Trivedi, I've passed you a document. If  
13 you could take a look at that and see if you recognize  
14 it?

15 A. Yes, I do, that's my CV.

16 Q. Does that accurately reflect your educational  
17 experience, your employment background and various  
18 honors and awards that you've received over the course  
19 of your career?

20 A. Yes, it does.

21 MR. SWEARINGEN: Your Honor, I ask that  
22 that be introduced as Exhibit 383.

23 THE COURT: Exhibit 383 will be marked as  
24 the CV of Dr. Harsh Trivedi.

25 (Marked Exhibit No. 383.)

1 BY MR. SWEARINGEN:

2 Q. And, Dr. Trivedi, if you could give us sort of  
3 the truncated version of the CV. Talk to us a little  
4 bit about your educational background starting off  
5 with --

6 A. Sure. In terms of my educational background,  
7 I attended a seven-year accelerated medical school  
8 program in which I completed both the undergraduate  
9 portion, as well as the medical school portion at  
10 Kennedy Medical School. This was in New York City. I  
11 completed my medical school portion at the Mt. Sinai  
12 School of Medicine in New York, New York.

13 From there, I attended a psychiatric residency  
14 at the Albert Einstein College of Medicine also in New  
15 York City. From there I completed my child psychiatry  
16 fellowship at Children's Hospital in Boston, which is  
17 affiliated with Harvard Medical School. That was my  
18 medical training. In addition to that, I have had  
19 health policy exposure by being a Congressional Fellow  
20 in the Washington D.C. office of US Senator Jack Reed.

21 In addition to that, I have also attended  
22 business school. I have my MBA from the University of  
23 Tennessee Haslam School of Business in Knoxville,  
24 where I was in the Physician Executive MBA program. I  
25 have also completed a psychoanalytic fellowship, which

1 is a psychiatric fellowship as well from NYU.

2 Q. As part of your legislative fellowship in  
3 Washington D.C., did you take part in actually  
4 drafting a legislation related to psychiatric issues?

5 A. I did. I was fortunate at the time that the  
6 healthcare legislative assistant was on a maternity  
7 leave so I was able to work with the senator on all  
8 healthcare related issues. In addition to that, I did  
9 have the pleasure of drafting legislation that passed  
10 both houses of Congress and was signed into law. That  
11 was specifically the Garrett Lee Smith Memorial Act,  
12 which provides funding for suicide prevention programs  
13 as well as for college mental health services.

14 Q. And here in the state of Tennessee are you  
15 involved if any policy or governmental organizations  
16 that are charged with shaping psychiatric mental  
17 health policies here in this state?

18 A. I continue to provide a number of hours of  
19 service to our state organizations. I am active with  
20 our Department of Mental Health as it convenes its  
21 crisis services task force work. I am also involved  
22 with the Tennessee Hospital Association. I am also  
23 involved with the Tennessee Association of Mental  
24 Health Organizations, which is a community mental  
25 health group. I am also active with the Tennessee

1 Psychiatric Association, as well as a local chapter  
2 for child psychiatry as well.

3 Q. Following the completion of your medical  
4 fellowship at Harvard, talk to us a little bit about  
5 your hospital-based appointments that you had.

6 A. Sure. After completing my training in Boston,  
7 I was fortunate to first work at Brown University's  
8 affiliated Bradley Hospital. This is a 60-bed  
9 inpatient child and adolescent psychiatric facility in  
10 East Providence, Rhode Island. There I got to partake  
11 in their building of a brand new 60-bed facility  
12 specifically for youth. That involved everything from  
13 philanthropy to the actual architectural drawings to  
14 staffing the services, as well as getting the clinical  
15 programs up and running. Of note to this particular  
16 case, we did have specifically a program for  
17 cognitively delayed youth at that facility, which is  
18 probably one of the best in the country. After that I  
19 was recruited to come to Vanderbilt, and I have been  
20 with Vanderbilt Psychiatric Hospital for the last five  
21 years in different capacities, as was described.

22 Functionally, I am the Chief Medical Officer  
23 for psychiatric services. I was involved in basically  
24 the renovation and turnaround of Vanderbilt's  
25 Psychiatric Hospital, as well as managing the clinical

1 providers and providing strategic direction for the  
2 psychiatric services at Vanderbilt, and now in my  
3 regional CMO role helping to define how psychiatric  
4 services should be provided across the state as we  
5 think about our health affiliate network.

6 Q. Dr. Trivedi, I've put another document in  
7 front of you that was marked in your deposition as  
8 Exhibit 88. If you could please take a look at that  
9 and let me know if you recognize that document.

10 A. I do.

11 Q. And what is it?

12 A. This is the report that I've prepared for this  
13 CON application hearing.

14 MR. SWEARINGEN: Your Honor, we ask this  
15 be introduced as Exhibit 88 to our proceeding.

16 THE COURT: Exhibit 88 will be marked as  
17 the report of Dr. Trivedi.

18 (Marked Exhibit No. 88.)

19 BY MR. SWEARINGEN:

20 Q. Dr. Trivedi, I wanted to start on page 4 of  
21 your report where you have put together a chart here  
22 that sort of lays out the various levels of  
23 psychiatric care, sort of a spectrum. If you would,  
24 just sort of walk us through what you were trying to  
25 demonstrate on this chart and explain it as you go,

1 please.

2 A. Sure. So in terms of the provision of  
3 psychiatric service, what is really important from a  
4 consumer perspective is how do you get access to the  
5 right type of care. The point of this specific chart  
6 is to really show that there are gradations in types  
7 of care that patients can receive. Most specifically,  
8 there's an underlying principle in all psychiatric  
9 care, which basically states that we want patients to  
10 receive care in the least restrictive treatment  
11 setting possible.

12 In the state of Tennessee if you are  
13 involuntarily admitted to a psychiatric hospital in  
14 addition to losing your civil liberties and being  
15 placed behind locked doors, you lose the ability to  
16 apply for a gun permit. It does come up when  
17 background checks are done when you are applying for  
18 certain jobs; so we are very mindful of the fact that  
19 we only want to put a patient behind a psychiatric  
20 locked door of an inpatient unit when there is no  
21 other possible place that they can go. So the reason  
22 for providing this table is to really talk about what  
23 are those other options.

24 So just starting off from the left, inpatient  
25 hospitalization is what you all have been discussing,

1 which is basically the patient spends 24 hours of the  
2 day within an inpatient psychiatric hospital. The  
3 average length of stay in the state of Tennessee is  
4 about seven days. These are generally people who are  
5 severely ill. And what I mean by that is patients who  
6 are at risk for imminent self harm or harm to others  
7 or folks that cannot be safely managed in the  
8 community. In terms of it being a least restrictive  
9 option, the answer to that would be a definite no.  
10 And in general of all the different things that we can  
11 provide in terms of psychiatric care, that is the most  
12 expensive in terms of costs of providing that care on  
13 a per day basis.

14           Taking one step down from there, we have  
15 partial hospitalization, which as it implies means  
16 that it's a lesser form. It's a substantially lesser  
17 form in the sense that you actually get to stay at  
18 home, return to your home, sleep there. You basically  
19 come in for treatment, pretty intensive treatment, for  
20 about six hours of the day. That can include  
21 therapeutic groups, meeting with your psychiatrist,  
22 having family meetings, all those types of things.  
23 This lasts on average for somewhere between 10 to  
24 14 days or about two weeks. In general, these are  
25 folks that are either becoming more ill and are not

1 quite sick enough to end up in a psychiatric inpatient  
2 unit, or these are folks that have specifically been  
3 making wonderful progress in terms of inpatient  
4 treatment, but now they're at a point where they can  
5 be safely managed in an out-patient level of care,  
6 which is what this is considered.

7           Taking a step just to complete that list, it  
8 is a better option as you think about least  
9 restrictive because you're not taking away anyone's  
10 civil liberties, and they are able to go home at the  
11 end of the day. In terms of cost of care it is  
12 generally less expensive than the cost of attending an  
13 inpatient psychiatric hospital stay.

14           The next option in terms of a step down from  
15 there would be an intensive out-patient program. This  
16 is generally about three hours per day. This can  
17 range in terms of treatment for about two to four  
18 weeks. These are patients who are even less ill from  
19 a severity perspective. This also would meet the need  
20 of being the least restrictive because the patient  
21 does not lose their civil liberties and is able to  
22 access care. It is less costly than either inpatient  
23 or out-patient hospital levels of care.

24           When we get to out-patient level of care, that  
25 is routinely what we think about when we're going to

1 our doctor's visit; it is that you're going in to see  
2 somebody for that one visit in the week. Duration of  
3 treatment can last months to years, depending on what  
4 you have going on. These are generally stable  
5 patients like you or I that are in the course of their  
6 normal daily lives but going in for these checkups or  
7 appointments as needed. It is deemed the least  
8 restrictive and it is the least costly type of care to  
9 provide as you're thinking about an orderly provision  
10 of services.

11 Two other things I did want to talk about:  
12 One is crisis stabilization, which has specifically  
13 been mentioned. Crisis stabilization is something  
14 that can provide 24-hour-a-day care of patients. In  
15 general in most states this occurs for about up to  
16 three days. These are pretty severely ill patients.  
17 But due to kind of their presentation, they have  
18 presentations where they can actually be adequately  
19 treated and basically de-escalated to a lower level of  
20 care within those three days. It is considered the  
21 least restrictive because these are always voluntary  
22 admissions. You cannot involuntarily admit someone to  
23 a CSU, which means that the patient is also free to  
24 leave whenever they choose to.

25 There is a cost of providing crisis

1 stabilization care, but it is less so than inpatient  
2 care, both in terms of the fact it's a shorter length  
3 of stay, but also the reimbursement on a day-to-day  
4 basis is lower as well.

5 The last thing, which I'll bring up, is  
6 residential care or in the addiction world what would  
7 be called a therapeutic community. So these are  
8 people that maybe have attempted inpatient care in the  
9 past. Upon discharge they are not able to maintain  
10 treatment goals and they really need something that is  
11 for a protracted amount of time. So generally with  
12 youth we call those residential treatment facilities.  
13 With adults it can either be residential, and in the  
14 addiction world they are called therapeutic  
15 communities.

16 The whole point of this is these are people  
17 with chronic types of illness. It is not least  
18 restrictive in the sense that, yes, people are in a  
19 facility for a long period of time, but they also tend  
20 to be voluntary in nature for the most part. There is  
21 a substantial cost, not on a day-to-day basis, but  
22 because they are basically in a treatment setting for  
23 four weeks up to six to nine months, in some cases.

24 Q. We've talked a lot in this case about  
25 inpatient hospitalization. On this spectrum that

1 you've provided, what percentage of total number of  
2 treatments being provided across this state are  
3 inpatient versus the others that you've identified?

4 A. So I will qualify this by saying I wouldn't  
5 even know how to begin getting to the actual  
6 percentage. If I had to say we have probably  
7 95 percent or more of the care provided in this state  
8 is actually non-inpatient based types of care. That  
9 would simply be looking at what type of billing goes  
10 into a billing system by every mental health provider  
11 and the location they're providing that care.

12 Q. And when you are trying to design an orderly  
13 mental health provision system in this state, where do  
14 you believe that the folks should be on the spectrum?

15 A. The folks in all of healthcare right now is  
16 basically how do you provide patient centered care.  
17 If you or I wanted to access services, where would we  
18 want to go and where would my specific patients want  
19 to go. They would want to be able to access that care  
20 from the comfort of their home to be able to access  
21 providers that can do that without being placed within  
22 locked doors, without losing their civil liberties,  
23 and without losing other privileges every other  
24 citizen has.

25 Q. There has been some suggestions made in this

1 case that we need to drastically increase the number  
2 of public hospital beds that we have in this state.

3 Do you disagree with that assertion?

4 A. No. There's an important thing to keep mind  
5 of in psychiatry specifically. For many years there  
6 was a trend of thinking about mental asylums. This  
7 was back in the 1850s, those type of things. And that  
8 really was because we didn't have good, adequate  
9 psychiatric care available. In the 1960s when  
10 anti-psychotics first came out, we saw a massive shift  
11 towards providing community-based care for patients  
12 with severe and persistent mental illness. So these  
13 are people who are life-long schizophrenics. They may  
14 hear things, see things. If they come off their  
15 medication, they may be apt to have dangerous behavior  
16 as well.

17 In terms of the shift in care, there's been a  
18 folks from the time that Ronald Reagan was President  
19 in terms of establishing community mental health  
20 centers to the present day, that Tennessee  
21 administration, in terms of saying we want patients to  
22 be able to access care that is in the community and  
23 not behind locked doors.

24 Q. Even if you were to agree that there needed to  
25 be an increase in public beds, would a project by a

1 for-profit provider of acute inpatient care, would  
2 that solve the type of problems that those issues were  
3 trying to deal with?

4 A. My apologies for forgetting the beginning part  
5 of that question. So there's an important thing to  
6 consider; we need to compare apples to apples. In  
7 documents that are prepared that talk about the state  
8 need per 100,000 patients in general we're talking  
9 about public beds. When we're talking about public  
10 beds or patients treated within psychiatric state  
11 facilities, we are talking about seriously and  
12 persistently mentally ill patients. So those are  
13 patients that we are saying would truly become  
14 psychotic, would be going for days without sleeping,  
15 would be folks that you or I would be quite scared of  
16 if we were to meet them on the street. That is very  
17 different than some of the conversation that's  
18 occurred within this CON trial in terms of saying that  
19 we need 50 beds per 100,000 for every single person  
20 that's out there. No, you or I should hopefully be  
21 able to get access to care at an out-patient level or  
22 any of the lower levels of care long before we get to  
23 the point where we have to require an inpatient  
24 hospital bed.

25 Q. As part of preparing your report in this case,

1 did you have the opportunity to go up to Johnson City  
2 to Woodridge and meet with Kasey McDevitt and Marlene  
3 Bailey and Dr. Borel, who is the medical director at  
4 Woodridge?

5 A. I did do that, yes.

6 Q. Tell us about that trip and what you were able  
7 to see and what you were able to learn.

8 A. Sure. One of the things that I will say is in  
9 my role at Vanderbilt, and thinking about what is  
10 right for patients, we make a point that if we are  
11 going to make a comment about any other facility or  
12 refer patients to any other facility, we need to have  
13 spent some time to see the facility, make some sort of  
14 ascertainment whether we're sending people to a quality  
15 place of care. So my conversation with the leadership  
16 there was really in the same way as if I want to refer  
17 a patient to them, which means I went there, I got a  
18 general lay of the land of what types of services they  
19 provide. We had a discussion regarding what things  
20 exist from a physical infrastructure perspective, what  
21 their units look like, what types of patients can they  
22 manage. I spent some time in their admitting area to  
23 look at how they huddle to figure out what is the best  
24 place to admit a patient to. I also spent some time  
25 touring the facility as well.

1 Q. During your visit there, did the folks at  
2 Woodridge talk to you about their operations and their  
3 occupancy level while you were there?

4 A. They did. We had a conversation about  
5 specifically the operation of the Woodridge facility.  
6 We had a conversation about their bed occupancy of  
7 somewhere around 85 percent. We had conversations  
8 about how they actively work with local providers as  
9 well as with their own team at Woodridge to be able to  
10 find a suitable bed for each patient that is referred  
11 to them. We also talked about how this is really a  
12 national issue and what is being done to combat  
13 concerns about the availability of beds.

14 Q. The fact that they discussed with you their  
15 occupancy levels and that they were running at or near  
16 or sometimes above 85 percent occupancy; was that  
17 troubling to you?

18 A. It is not. If you look across the field at  
19 Vanderbilt, our occupancy levels are about 85 percent  
20 as well. I think if you looked at SBH's documents as  
21 well, their facilities run at 85 percent as well. The  
22 thing that I would say from my own national work is  
23 some of the things that are going on with healthcare  
24 reform is really to provide a better network of beds  
25 across a larger geography. The best example I can

1 give you is the University of Pittsburgh Medical  
2 Center, UPMC. They actually operate about 600 beds  
3 across eight or nine different hospitals. They have  
4 actually been able to get to occupancy rates of about  
5 96 percent in psychiatry.

6           The reason why this is important is because if  
7 I'm admitting a patient who is, let's say psychotic,  
8 hearing voices, I am not going to want to put a  
9 geriatric elderly patient who maybe has some memory  
10 difficulties into that same space. But if I have  
11 other units to choose from or spaces to choose from, I  
12 can best meet the needs of the population in the  
13 community, get to higher occupancy rates and actually  
14 achieve better utilization of the beds that are there.

15           The second part of this is I would love to be  
16 in a situation where patients can access out-patient  
17 resources in the local community that they're in.  
18 Even when the State closed Lake Shore, Lake Shore's  
19 mission was to serve a 26-county area. Inpatient  
20 psychiatric beds are not designated to be in every  
21 single neighborhood in every single community. That  
22 is really something that is a little bit more of a  
23 geographic spread. So in that sense, what I would say  
24 is as we think about what is the appropriate provision  
25 of care, we have to keep in mind that inpatient

1 services, getting back to the least restrictive  
2 comment, are really accessed when every other part of  
3 the system has failed or you are so severely ill that  
4 you can't get better anywhere else.

5 Q. Would it then be your expectation that the  
6 local out-patient providers, somebody like Frontier  
7 Health, for instance -- are you familiar with the  
8 Frontier Health organization?

9 A. I am.

10 Q. Would it be your expectation that somebody  
11 like Frontier Health would be the one who would have  
12 the more geographically dispersed services versus the  
13 inpatient providers in any particular community?

14 A. Exactly. So throughout our state, and I can  
15 tell you through my work with the Tennessee  
16 Association of Mental Health Organizations, our  
17 community mental health centers are doing a wonderful  
18 job of being geographically distributed. Many of them  
19 are providing same-day appointments to psychiatric  
20 patients. Mobile crisis teams can come to the  
21 location where you are as opposed to you needing to  
22 travel to an emergency room or a facility to get the  
23 assessment done. Many of them are providing in-home  
24 services for patients that really would do better in  
25 an in-home setting. Many of them have robust

1 telemedicine programs as well. So these are a number  
2 of the things that we as a state are working on to  
3 provide care for the patient in the most comfortable  
4 and most conducive of treatment location possible.

5 Q. In addition, and in line with those types of  
6 services, have you learned about the adolescent CSU  
7 that Frontier Health and Mountain States are  
8 partnering on?

9 A. I have learned about that. I have also been a  
10 part of the initial crisis team meetings that occurred  
11 through the Department of Mental Health and with the  
12 TennCare Bureau for about the last two years.

13 Q. In your role that you just described, what  
14 have those discussions been about and what is the sort  
15 of direction that the State is trying to take with  
16 those types of services?

17 A. Sure. So while remaining agnostic of anything  
18 else, but I will say I am glad that our governor as  
19 well as our Commissioner of Mental Health has made a  
20 folks on allowing patients to get better access at  
21 lower levels of care. The CSU, crisis stabilization  
22 unit, is something that has been enacted across  
23 multiple states in the country. We have had adult CSU  
24 beds in Tennessee. I have worked in these facilities  
25 in other states. They work extremely well for

1 patients who are in acute crisis who really need  
2 something like being restarted on the medicines that  
3 were already working for them. If there is an acute  
4 thing like somebody just broke up with their  
5 boyfriend, somebody happened to just be fired from  
6 their job, you can do a lot of work within three full  
7 days within a CSU to get people on the right track and  
8 not needing inpatient hospitalization.

9 In regards to adolescents specifically, what  
10 we run into in child psychiatry is in our emergency  
11 rooms you have younger children and you have  
12 adolescents. A number of our adolescents are bigger  
13 than you and I, and then it becomes an issue of where  
14 exactly can you provide care so that they can remain  
15 safe. Younger children generally tend not to do very  
16 self-destructive or self-injurious things. So a  
17 five-year old I'm not as concerned about them going  
18 home and finding a gun and shooting themselves as a  
19 way to kill themselves. A 17-year old I am much more  
20 worried about that.

21 A CSU can provide that level of care for that  
22 adolescent, which is why the State has only talked  
23 about adolescent CSUs, not children CSUs, and it can  
24 do it in a way where family can be involved in that  
25 care. We can provide that care in a regional manner

1 and more specifically patients can then be discharged  
2 without ever needing inpatient services.

3 Q. And do you consider a crisis stabilization  
4 unit to be a waiting room of sorts for inpatient  
5 hospitalization or is it an alternative to inpatient  
6 hospitalization?

7 A. It is definitely not a waiting room. I can  
8 tell you from my own experiences, having worked in New  
9 York City and having trained there, there are adult  
10 CSUs that will see, for example, people that come in  
11 intoxicated or currently high on substances. During  
12 that three-day period you can get them safely off  
13 those medicines, figure out what's going on and then  
14 discharge them to out-patient services for ongoing  
15 care. You can do the things I mentioned in terms of  
16 getting patients back on their medicines so that they  
17 can actually do better and be stabilized. You can  
18 also resolve acute stressors. And for a vast number  
19 of the people if a thought is that somebody is going  
20 to end up needing inpatient care the CSU team would  
21 directly admit them to an inpatient hospital. They  
22 are not going to take them on for three days to fail  
23 and then have them start again from a day one  
24 perspective on an inpatient unit. That's not how CSUs  
25 are made.

1 Q. And the CSU that's being finalized by Frontier  
2 Health for this area, what would your expectation be  
3 of the impact it would have on adolescent admissions?

4 A. Sure. So what is planned is a 12-bed CSU.  
5 Just from only looking at a length of stay criteria,  
6 figuring that an average length of stay for an  
7 inpatient stay is seven days, for a CSU is about three  
8 days. A 12-bed unit is the same impact as adding 28  
9 inpatient adolescent beds.

10 Q. We were talking a little bit earlier about  
11 your experiences when you went and spoke with the  
12 folks at Woodridge about their occupancy levels.  
13 Would it be odd or out of norm in your experience that  
14 a hospital running at 85 percent full has some periods  
15 where they are completely full and have some folks  
16 waiting to get a bed?

17 A. Sure. So I can give you a specific example of  
18 that. At Vanderbilt we have a 26-bed child and  
19 adolescent unit. We very specifically don't dictate  
20 that, you know, so many beds will be for this versus  
21 so many beds will be for this, because there are times  
22 on our inpatient child and adolescent unit we may have  
23 24 adolescents and two children. There are times  
24 where we may have 22 children and four adolescents.  
25 It's the nature of psychiatric care, which is you

1 don't know what type of patient is going to present  
2 themselves in the emergency room, and you can have  
3 massive shifts in any given direction.

4           The second thing is the reality of psychiatric  
5 care in Tennessee isn't when hospitals have capacity.  
6 All hospitals have capacity. In those days where  
7 there isn't capacity, guess what -- so I'll speak  
8 about middle Tennessee specifically.

9           When Vanderbilt doesn't have a bed, I can  
10 promise you there are six other hospitals in middle  
11 Tennessee that don't have a bed either. That's really  
12 because of the temporal way in which patients show up  
13 for care. You can't build entire hospitals to be  
14 empty for all the other days for those particular days  
15 when there isn't a bed anywhere.

16 Q.       You may have answered this question right  
17 then. Does the periodic times where patients are  
18 having to wait, in your mind, create a need for a new  
19 psychiatric hospital, in this case a 72-bed hospital?

20 A.       No, because the specific issue here is how do  
21 you have an orderly production of healthcare services.  
22 When you think about a facility having to defer an  
23 admission, that is a single point in time. That does  
24 not mean that two hours from now, six hours from now,  
25 twelve hours from now, there won't be an available

1 bed, someone won't be discharged or, if anything, six  
2 other hospitals won't have beds either.

3 Q. For individuals who are, for instance, who  
4 come to the hospital and are having to wait a few  
5 hours to get admitted into an available bed, are those  
6 individuals just left in the hallway to care for  
7 themselves?

8 A. I can very specifically tell you the  
9 experience at Vanderbilt is that every single one of  
10 those patients has someone with them every single  
11 moment that they're there. So they have what is  
12 called a sitter. In addition to that, the emergency  
13 room nurse will be checking in on them as well. We  
14 have psychiatric consultants that will see the patient  
15 while they are in the emergency room waiting for that  
16 admission.

17 The other thing is that we will also track  
18 that person over time. So it may be that 12 hours  
19 later we may say, although a bed has opened up, they  
20 actually don't need inpatient hospitalization anymore.  
21 We would much rather have them go to a partial  
22 hospitalization program or some other lower level of  
23 care. That's always our goal.

24 Q. And based on your conversations with the folks  
25 at Woodridge and your other providers that you meet

1 with on a regular basis through your role with the  
2 State, is it your understanding that the same type of  
3 care is being offered in northeast Tennessee and  
4 southwest Virginia?

5 A. That is my understanding as well. I did speak  
6 with Dr. Lobell who discussed -- Borel, sorry -- who  
7 very much discussed that he is one of the people that  
8 does go and provide consults in the emergency room  
9 over at Mountain States Health Alliance emergency  
10 room.

11 Q. Do you believe that the addition of a 72-bed  
12 psychiatric facility here in Kingsport as proposed by  
13 this applicant is needed, based on your review of the  
14 clinical situation in upper East Tennessee?

15 MR. WEST: Your Honor, we certainly  
16 respect Dr. Trivedi and his accomplishments and all,  
17 but I don't think he's been offered as an expert in  
18 health planning. He certainly has a lot of experience  
19 in medicine, and he has related his public policy  
20 experience. But my understanding is that he was  
21 tendered as a clinical expert and not a health  
22 planning expert; therefore, I object for the record to  
23 his being offered as a consultant or an expert on need  
24 or the health planning itself.

25 MR. SWEARINGEN: I think Dr. Trivedi's

1 qualifications have been established by the record.  
2 I'm not asking him for a health planning based  
3 opinion. I'm asking him for a clinical based opinion.  
4 The applicant in this case has suggested that because  
5 on a few occasions that Woodridge has got some wait  
6 times and that their occupancy level is high, that  
7 that necessitates the need for a new psychiatric  
8 hospital. I think Dr. Trivedi is well qualified both  
9 from his own administrative experience and his policy  
10 experience to opine as to whether it's needed and  
11 whether it's in the orderly development of mental  
12 health services in this area to build a new hospital.

13 THE COURT: I think, Mr. West, based on  
14 his background, the fact that he has been in the area,  
15 he went up there and talked with the Woodridge people,  
16 he can offer an opinion. Of course, that is subject  
17 to your cross-examination as to the basis for that  
18 opinion.

19 MR. WEST: Thank you.

20 BY MR. SWEARINGEN:

21 Q. And just so my question is clear, Dr. Trivedi,  
22 I'm asking you as a clinical expert, as well as  
23 someone who has written healthcare legislation who is  
24 involved in essentially all major organizations in  
25 Tennessee that govern the planning of psychiatric

1 services, do you believe that the addition of a new  
2 72-bed psychiatric facility in Kingsport is needed and  
3 would contribute to the orderly development of mental  
4 healthcare in that region?

5 A. I will be very careful to only opine about  
6 things that I feel some expertise. Adding additional  
7 inpatient beds would only be duplicative, as I stated  
8 in my report. I would much rather see, when we're  
9 talking about an orderly provision of services, a  
10 greater availability of lower levels of care where  
11 patients can get care without having to be locked  
12 behind a psychiatric inpatient unit.

13 MR. SWEARINGEN: I'll pass the witness,  
14 Your Honor.

15 CROSS-EXAMINATION

16 BY MR. WEST:

17 Q. Dr. Trivedi, you and I met, as I said earlier.  
18 It seems like a long time ago, but it was just last  
19 week, I believe.

20 A. Yes, I believe so.

21 Q. I'm Bill West. You and I met over at Butler  
22 Snow for your deposition. As I indicated in my  
23 objection, you certainly have a distinguished record  
24 and a lot of jobs over at Vanderbilt. I'm still not  
25 sure I know all of them. But one of the things I

1 wanted to ask you was in relating your last comments,  
2 would the construction of a new psychiatric hospital  
3 in Kingsport in Sullivan County in East Tennessee,  
4 would it prevent the construction of the adolescent  
5 CSU?

6 A. It would not prevent construction of the  
7 adolescent CSU. I do believe that it would have a  
8 negative impact on Woodridge.

9 Q. But as far as the concerns you expressed with  
10 the development of a new crisis stabilization unit in  
11 Washington County, which is going to be in Gray, which  
12 is over in Washington County, that process can go  
13 forward regardless of whether SBH-Kingsport is  
14 constructed or not; is that correct?

15 A. The process can go forward. But if we're  
16 talking about the orderly development of services, the  
17 requirement for as many child and adolescent beds  
18 would not exist because there would be another way to  
19 access those services.

20 Q. So then you are opining on the health planning  
21 process?

22 A. I am saying that this is a part of the state  
23 in which there isn't a massive explosion of youth who  
24 are entering adolescents, which I can say as a member  
25 of the public and not as a health planning expert,

1 it's not Williamson County by any stretch of the  
2 imagination in terms of how many kids are going into  
3 local schools. It is an aging population is one.

4 The second part is the kids that end up  
5 clinically needing to be hospitalized are the ones  
6 where you are worried about imminent risk for  
7 self-harm or violent behavior. What I would say is if  
8 you can provide that care at a CSU that has already  
9 planned to be opened in terms of the orderly  
10 development of that care, the concerns that I bring  
11 are from my own personal experience.

12 I was recruited to Vanderbilt at a time when  
13 its psychiatric hospital was losing about \$3 million a  
14 year. I was involved in that turnaround because that  
15 was sufficient for the medical center to think about  
16 selling our psychiatric hospital to a for-profit  
17 entity. So my concern in terms of this case is if we  
18 do this, there's a CSU being built, 77 more beds are  
19 constructed, that will impact the bottom line of  
20 Woodridge to a point where it may not be a viable  
21 hospital for the community.

22 Q. You said 77 beds. Are you referring to the  
23 SBH-Kingsport?

24 A. I'm sorry. 80 beds at Woodridge. We have 88  
25 beds in our facility.

1 Q. But you know the SBH-Kingsport is proposing 72  
2 beds?

3 A. You are correct.

4 Q. Okay. I don't mean to belabor the point, but  
5 in your deposition I believe you told me that you  
6 haven't previously been involved in the CON,  
7 Certificate of Need, process in Tennessee?

8 A. No, I have not. I have been in this state for  
9 about five years. In terms of actual court  
10 appearances it's usually in mental health court, not  
11 in this type of court.

12 Q. Do you draft CON applications for Vanderbilt,  
13 for example?

14 A. I do not.

15 Q. So from the standpoint of being familiar with  
16 the CON process from the application standpoint to the  
17 presentation standpoint for the HSDA, you have not  
18 been personally involved in that?

19 A. I have not been involved in the creation of a  
20 CON application. I am involved as it pertains to us  
21 reviewing CON applications that come through and  
22 reviewed by Vanderbilt University in general. And so  
23 I provide input on those psychiatric ones.

24 Q. Have you appeared before the HSDA before?

25 A. I have not.

1 Q. So truly your opinion is, your clinical  
2 opinion, and your observational opinion in terms of  
3 your specialty and that type of thing, but not a  
4 health planning?

5 A. Not as a health planning expert, simply as  
6 somebody who practices day in and day out and happens  
7 to be sitting on a number of committees that think  
8 about these problems daily about how it impacts  
9 Tennessee.

10 Q. One of the things we talked about in your  
11 deposition is the issue of can a hospital operate a  
12 CSU. What is the rule in Tennessee?

13 A. There isn't a rule per se that I'm aware of.  
14 In general, the Department of Mental Health's stance  
15 has been, and these are not their words, it would be  
16 akin to the fox guarding the chicken coop in the sense  
17 that there is no desire in the state to have a  
18 hospital be the entity that is also managing the  
19 mobile crisis team or the CSU beds, because there is  
20 an inherent conflict of getting more people admitted  
21 to the inpatient unit because there is an availability  
22 of beds, would be the perception.

23 Q. It might turn into a marketing effort as  
24 opposed to an assessment effort, is that --

25 A. It may -- there is a risk of potentially more

1 patients being admitted than need to be based on  
2 availability on any given particular day for that  
3 entity.

4 Q. And Mr. Swearingen referred I think in his  
5 questions to you about an adolescent CSU being a  
6 partnership between Mountain States and Frontier. If  
7 hospitals can't operate or own the CSU, then this  
8 structure is really not a partnership in the legal  
9 sense in terms of sharing revenues, is it?

10 A. I do not know what the specific financial  
11 agreement is. My understanding is Mountain States is  
12 contributing to the renovation of the facility, so  
13 there is a place for Frontier, which is the community  
14 mental health organization, to operate a CSU for all  
15 of our community mental health organizations. There  
16 isn't a margin from which to have funding to build out  
17 a brand new CSU. That would not be a viable concept.

18 Q. I understand. So the relationship, the true  
19 relationship, as I understand it between -- let me ask  
20 you this question: What you understand is Mountain  
21 States is essentially making an in-kind contribution  
22 on the construction side of things and then they'll  
23 become the landlord for the adolescent CSU?

24 A. I don't know whether they would be a landlord  
25 or not. What I would say is that in the references

1 that were recently made about the community health  
2 needs or community health assessment, this could be  
3 something that Mountain States could be proud of as  
4 providing something that the community needed and  
5 providing for that renovation. I don't know what the  
6 financial or the legal relationships are between the  
7 two.

8 Q. Okay. So you have not been involved in the  
9 detailed negotiations concerning the development of  
10 this CSU?

11 A. No, I've only been involved from the state  
12 perspective thinking about what is the best way to  
13 build out these adolescent CSUs and thinking about  
14 what is the best way to provide that care regionally  
15 closer to where our kids are.

16 Q. And currently there are scattered CSUs around  
17 Tennessee, but they're only for adults; is that  
18 correct?

19 A. Correct.

20 Q. And this will be the first adolescent CSU?

21 A. That will be the first adolescent CSU.  
22 There's also one planned in middle Tennessee as well.

23 Q. Where will that be located?

24 A. I do not know. That's a conversation between  
25 the Commissioner of Mental Health's office and our

1 local mobile crisis team, which is mental health  
2 co-op.

3 Q. So they're essentially the mental health  
4 center analog here in middle Tennessee?

5 A. Correct. It's the equivalent of Frontier but  
6 for middle Tennessee.

7 Q. You had referenced that the 12-bed CSU for  
8 adolescents in upper East Tennessee will have a three  
9 to four-day length of stay. I understand it's usually  
10 three but can go to four; is that correct? on the  
11 adult side; is that true?

12 A. Yes. So the comment that I will make is in  
13 terms of CSU planning at a national level, there's  
14 been a desire to keep it at 72 hours or three days.  
15 In the conversations that we had regarding the  
16 adolescent CSU with the crisis services team, there's  
17 a feeling that particularly when you're talking about  
18 an adolescent, where you need more active  
19 participation of parents, you may need 96 hours and  
20 not 72 hours to get all the things in place so the  
21 child can then be discharged to a safe home. Because  
22 many times, for example, DCS is involved. You may  
23 need a DCS worker to go home -- go and evaluate the  
24 home before that child is cleared for discharge.  
25 That's where that 72-hours is not sufficient.

1 Q. I understand. But my question really more is  
2 with a 12-bed CSU. How do you arrive at the same  
3 impact as a 28-bed inpatient setting?

4 A. So how I get to that is thinking from the  
5 perspective as someone who manages inpatient  
6 psychiatric beds. When I know that I admit a patient  
7 from the emergency room on to an inpatient bed, I know  
8 that the average length of stay is seven days. Once  
9 that bed is occupied, I can't fill that bed with  
10 another patient. When we're talking about the CSUs,  
11 if the average length of stay is let's say three days,  
12 if I admit the same patient into that one bed three  
13 days later, on day four I can admit another patient to  
14 that same bed. On the sixth day that patient gets  
15 discharged. On the seventh day the third patient  
16 comes in. That's how you get to about two and a third  
17 times more capacity for CSU as opposed to inpatient  
18 when you are thinking about volume of patients that  
19 can be treated in the same bed.

20 Q. I understand. So you're assuming 100 percent  
21 occupancy the whole time?

22 A. I am assuming that there are inherent  
23 inefficiencies in admitting patients to inpatient  
24 units, as well as CSUs. The big thing in CSUs, which  
25 is great, is that every CSU room that is constructed

1 is a single occupancy; so there is actually less  
2 inefficiency there than on the inpatient side. So if  
3 anything, the impact could be even greater than 28.

4 Q. So you don't have the problem of having a  
5 female patient with a male patient who needs admission  
6 in a double room so you can't admit the male  
7 immediately; is that what you're talking about?

8 A. Correct.

9 Q. And what will be the reimbursement per day  
10 from the State or TennCare or whomever for the  
11 adolescent CSU?

12 A. I do not know, I am not a party to those  
13 negotiations. My understanding is that's a  
14 negotiation that Frontier would have to have directly  
15 with the managed care organization through the  
16 TennCare Bureau.

17 Q. In your links with the whole mental health  
18 system in Tennessee, which I understand and certainly  
19 respect, what is the reimbursement per day for an  
20 adult CSU? Because those are all funded by mental  
21 health, as I understand it.

22 A. They are funded by mental health. We do not  
23 operate any of those beds; so I don't know the exact  
24 numerical amount.

25 Q. All right. What about the cost of operating a

1 CSU? The staffing cost, for example.

2 A. Sure.

3 Q. How do those compare -- how does the staff  
4 compare with the staff of an inpatient psych hospital  
5 that has a lot of two double bed occupancy rooms?

6 A. Well, in general what I will say is that  
7 inpatient psychiatric hospitals have greater affixed  
8 costs. It is more expensive to operate an inpatient  
9 unit as compared to a crisis stabilization unit. In  
10 general I can say that reimbursement for an average  
11 inpatient day is greater than the reimbursement for an  
12 average CSU day, but I couldn't tell you the exact  
13 numbers of how that works out.

14 Q. All right. With greater affixed costs,  
15 generally the inpatient psychiatric hospitals are  
16 bigger structures, for example, like Vanderbilt, for  
17 example?

18 A. Correct.

19 Q. At Vanderbilt do you know what the actual cost  
20 per day of an inpatient day in your psychiatric  
21 facility is?

22 A. I am not the financial expert; so I wouldn't  
23 want to misquote.

24 Q. But you will agree then whatever the costs  
25 are, the charges, to whoever the payor is, whomever

1 the payor, whatever, is higher or higher than the  
2 costs?

3 A. Hopefully you're getting reimbursed more than  
4 your costs, otherwise --

5 Q. I just meant the charges that go out.

6 A. Hopefully they are higher as well.

7 Q. Both. You hope both are higher. One is going  
8 to be higher and you hope the other one is too?

9 A. Agree.

10 Q. As you know, Woodridge has a 12-bed child and  
11 adolescent unit. Given what you said about the  
12 utilization of the adolescent CSU in Gray up in  
13 Washington County, what do you project the impact on  
14 utilization at Woodridge will be in its child and  
15 adolescent unit?

16 A. I am not a health planning expert, which I  
17 will state again, but my sense is that there would be  
18 less of a need for inpatient child and adolescent beds  
19 if you had an adolescent CSU functioning in the same  
20 geographic area. That honestly is a good thing for  
21 providing the right care to the right patient.

22 Q. Well, my point is you're concerned about the  
23 financial status of Woodridge; are you not?

24 A. I am.

25 Q. It has been expressed by various witnesses and

1 been an issue in this case about the cost or the loss  
2 of revenues by having another provider. Would it also  
3 be true that if the adolescent CSU opens in Gray up in  
4 Washington County that the revenues at Woodridge would  
5 drop at least for the child and adolescent beds?

6 Because as much as I understand, you're saying much of  
7 the inpatient adolescent business will shift to the  
8 CSU or be taken care of at the CSU?

9 A. I think there are two parts off the answer for  
10 that one. The first is when we're talking about the  
11 organized delivery of care, we are talking about  
12 Woodridge being able to work with a community partner  
13 in terms of Frontier to provide care that is least  
14 restrictive. The second part is it's a question of  
15 magnitude. Opening a 12-bed CSU is very different  
16 than opening a 77-bed empty hospital that currently  
17 does not have any volume.

18 Q. But my question is narrower than that. My  
19 question to you is that it has been projected or it's  
20 been stated in this case -- let's just assume. I  
21 don't know if it was stated to you, but that the  
22 margins of profitability, although they're a  
23 non-profit, the excess of revenue over expenses at  
24 Woodridge has been narrow. So a portion, a  
25 significant portion, of the revenue at Woodridge comes

1 from the operation of their 12-bed child and  
2 adolescent unit?

3 A. That may be the case.

4 Q. Well, it has relatively high occupancy and has  
5 a pretty high Medicaid load that it will at least be  
6 getting Medicaid patients. You're familiar -- as an  
7 MBA you're familiar with contribution margin analysis?

8 A. Uh-huh.

9 Q. So if Woodridge is concerned in our case about  
10 losing Medicaid patients to SBH-Kingsport because  
11 there's a contribution margin that they will no longer  
12 get for Medicaid, which is positive for them per case,  
13 then if those cases don't come to Woodridge because  
14 they're being handled through the CSU and Frontier's  
15 out-patient efforts, won't there be a loss of revenue  
16 at Woodridge from the year that opens, compared to the  
17 previous year because they've lost that contribution  
18 of margin from those TennCare patients?

19 A. Yes. They will have lesser contribution from  
20 those patients. I think the thing to keep in mind for  
21 all of our major hospital operators is even at  
22 Vanderbilt what I would say is if I could get a  
23 patient into a lesser restrictive place and that was  
24 the right place for the patient, that is what I would  
25 be fine with even if I lost the contribution margin.

1           So I think there's a part that we're missing  
2 here, which is why I present that first table. We've  
3 not discussed the concept of medical necessity. What  
4 is the right level of care that a patient needs to get  
5 better for how they're presenting. The difficulties  
6 here, we're assuming that every single patient, the  
7 only way they can get care is to end up in an  
8 inpatient psychiatric hospital. Personally for me, if  
9 I could avoid an inpatient hospitalization and allow  
10 somebody to get care elsewhere, that is the right  
11 thing to do for the patient. That is what I'm  
12 referring to.

13           Q.       Does the Strategic Behavioral Health CON  
14 application assert that every patient who needed care  
15 needed to go to a hospital?

16           A.       A lot of the conversation that's been  
17 occurring in this trial about -- when we're thinking  
18 about should the bed center be 30 beds per 100,00 or  
19 50 beds per 100,000, when we're talking about the  
20 occupancy rate of 85 percent, we're making an  
21 assertion that this is the only way that people are  
22 getting access to that care, or if we don't provide  
23 additional services, in some way we are restricting  
24 Tennesseans from getting the right access to care. I  
25 guess what I'm trying to get across to you is there

1 are many flavors of psychiatric care and there are  
2 many different ways to access care that are actually  
3 cheaper and better for the patient.

4 Q. I don't -- I mean, what indications have you  
5 seen that SBH-Kingsport believes that the beds are the  
6 only solution? Because I will ask you if Dr. Jessee,  
7 who is a senior official, you may know him at Frontier  
8 Health, testified that they through their dispersed --  
9 they are a widely dispersed out-patient service system  
10 and they had 40,000 individual patients, not just  
11 contact, but individual patients over that whole  
12 region; not just Tennessee, but a little in southwest  
13 Virginia as well, but a good bit in Tennessee.

14 A. Sure.

15 Q. And despite that, despite those widespread and  
16 despite the presence of an adult CSU in Johnson City  
17 run by Frontier, despite all of that, the utilization  
18 rate of their hospital at Woodridge has been climbing  
19 dramatically and is well above 85 percent, on many  
20 days it's 95 percent, which I understand. I've been  
21 to Vanderbilt, and I know it's busy. But my question  
22 is we already have a widely-distributed out-patient  
23 services sector, Frontier. We already have an adult  
24 CSU. So, you know, why would that not prevent -- why  
25 would that not bring down the occupancy rate at

1 Woodridge, which you assume that the adolescent CSU  
2 will do for the adolescent wing?

3 A. I'm going to have to ask you to repeat that  
4 question. I didn't understand it myself.

5 Q. I would like to hear it myself. Let me back  
6 up. I will say, I don't know if you were here for  
7 Dr. Jesse's testimony --

8 A. I was not.

9 Q. But you know Frontier is a wide-spread  
10 regional mental health center; is that correct? And I  
11 will say to you that my understanding of his testimony  
12 was that they had 40,000 individual patients last year  
13 over a widespread area. And we have an adult CSU or  
14 there is an adult CSU in Johnson City. And despite  
15 all that, and I'm glad, you know, that's a good effort  
16 by all those institutions and by Woodridge, but their  
17 occupancy keeps rising at Woodridge, and that's mostly  
18 adults. So the presence of the CSU doesn't seem to  
19 have retarded the growth in inpatient utilization.  
20 How would you respond to that?

21 A. The difficulty of that assertion is if you  
22 kept every single variable the same you could say,  
23 yes. You know, if you kept the exact population the  
24 same, how many people are coming in for treatment the  
25 same, yes, a CSU would definitely impact that. We

1 happen to be in a state, and there was some  
2 conversation about the Affordable Care Act, we're in a  
3 state that has chosen not to expand its TennCare  
4 program. We're in a state where it is difficult to  
5 access certain services; so I think in terms of the  
6 conversation about what is the appropriate  
7 organization in terms of providing an organized set of  
8 services, the thing to keep in mind is we have limited  
9 TennCare dollars to cover the entire state's need.  
10 Whether you're talking about grants or Medicaid  
11 dollars, it's all still coming out of the same state  
12 pot of money. The comment I'm trying to get across is  
13 really, as we're talking about providing psychiatric  
14 services in an organized manner, adding 72 beds is not  
15 the answer to that. Yes, you'll be able to fill the  
16 beds. You may even get the State to pay for those  
17 beds. But those are dollars that we then don't have  
18 for Tennesseans for lots of other things. That's  
19 really the message.

20 Q. Well, not all the patients will be funded by  
21 the State.

22 A. They won't be, but every one that is is that  
23 much less money to put towards CSUs, partial hospital  
24 care, intensive out-patient care and out-patient care  
25 in our community and to health organizations as well.

1 Q. Do you know that SBH-Kingsport does plan to  
2 have out-patient hospitalization services, partial  
3 hospitalization services?

4 A. Yes.

5 Q. On a less controversial topic, Vanderbilt  
6 treats children in its inpatient psychiatric hospital;  
7 is that true?

8 A. Yes, we do.

9 Q. And what is the dividing line? Is it age 12  
10 that they become an adolescent and everybody below 12  
11 is --

12 A. It is very much a developmental answer,  
13 depending on how the patient presents. In general  
14 what I will say is it's somewhere around 13 years of  
15 age.

16 Q. All right. And you, yourself, are you a child  
17 psychiatrist?

18 A. I am. I am double-boarded in general  
19 psychiatry as well as child psychiatry.

20 Q. Is there any shortage in Nashville of  
21 psychiatrists?

22 A. It depends on who you ask. What I will say is  
23 there is a national shortage in terms of child mental  
24 health providers across every profession, not just  
25 psychiatrists.

1 Q. A couple of final questions before I want to  
2 consult with my colleague. The function of a crisis  
3 stabilization unit, you have pretty much described it  
4 as a sort of front end, you know, initial. And we may  
5 have covered this in your deposition. Do psychiatric  
6 hospitals ever discharge to the CSU?

7 A. No. The whole point of having a CSU is that  
8 you see patients when they're in their moment of  
9 crisis, and you specifically stabilize it within a  
10 short amount of time so that they can access  
11 out-patient services instead of coming into the  
12 hospital.

13 Q. But there will be some, however small,  
14 population of patients coming in for the first time  
15 where they may have to proceed on to the hospital; is  
16 that correct?

17 A. As good as any of us may think we are, we  
18 can't predict the future in psychiatry or in other  
19 parts of medicine. There are patients who, despite  
20 our best efforts, won't get better.

21 Q. Dr. Trivedi, I don't mean to insult you, but  
22 are you being compensated for your services?

23 A. Yes, I am.

24 Q. And how much are you being paid?

25 A. \$500 an hour.

1 Q. About how many hours do you have in the case  
2 so far?

3 A. I think probably somewhere around 20 to 25.

4 Q. On that basis, that concludes my  
5 cross-examination.

6 MR. SWEARINGEN: No further questions,  
7 Your Honor.

8 THE COURT: Thank you. Doctor, you can  
9 step down.

10 THE WITNESS: Thank you.

11 MR. SWEARINGEN: We ask that Dr. Trivedi  
12 be excused.

13 THE COURT: Yes, you can.

14 (Proceedings adjourned at 4:30 p.m. to be  
15 reconvened at 9:00 a.m. on July 31, 2015.)

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BEFORE THE TENNESSEE  
HEALTH SERVICES AND DEVELOPMENT AGENCY  
NASHVILLE, TENNESSEE

IN THE MATTER OF: )  
 )  
SBH-KINGSPORT, LLC, )  
 )  
Applicant, )  
 )  
vs. ) Docket No.  
 ) 25.00-126908J  
TENNESSEE HEALTH SERVICES )  
AND DEVELOPMENT AGENCY, )  
 )  
Respondent, )  
 )  
and )  
 )  
MOUNTAIN STATES HEALTH )  
ALLIANCE, )  
 )  
Intervenor. )  
 )  
\_\_\_\_\_ ) VOLUME 5 OF 5

TRANSCRIPT OF PROCEEDINGS

Taken before Administrative Law Judge Leonard Pogue

Commencing at 9:00 a.m.

July 31, 2015

**ORIGINAL**

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SBH-KINGSPORT 001405

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NONE MARKED

1 P R O C E E D I N G S

2 THE COURT: Good morning, everyone.

3 (In Unison): Good morning.

4 THE COURT: Are we ready to proceed with  
5 the next witness?

6 MR. SWEARINGEN: We are, Your Honor.  
7 Mountain States would call Mr. Alan Levine.

8 ALAN LEVINE

9 was called as a witness, and after having been first  
10 duly sworn, testified as follows:

11 DIRECT EXAMINATION

12 BY MR. SWEARINGEN:

13 Q. Can you please state your full name.

14 A. Alan Morris Levine.

15 Q. And, Mr. Levine, what is your current job  
16 title and occupation?

17 A. I'm the president and chief executive officer  
18 of Mountain States Health Alliance.

19 Q. And how long have you been serving in that  
20 role?

21 A. Since January, early January 2014.

22 Q. Can you provide me with a little bit of your  
23 background, your education, where you've worked  
24 leading up to this time?

25 A. Undergraduate degree, University of Florida,

1 in health education. My graduate degree, MBA and a  
2 Master of Health Science, from the University of  
3 Florida.

4 I spent the last 20, 25 years in various  
5 positions, starting off as a hospital administrator.  
6 Served as a deputy chief of staff and senior health  
7 policy adviser to the governor of Florida.

8 Served as the secretary of health  
9 administration for the State of Florida, overseeing  
10 the Medicaid program. And we were the single state  
11 agency for administration of all Medicaid-funded  
12 programs, including mental health and acute care  
13 services.

14 Ran the fifth largest public hospital system  
15 in South Florida as a CEO, where I was responsible for  
16 a provider service network to provide services to  
17 children and adults on Medicaid and uninsured. Went  
18 from there to Louisiana.

19 I was the secretary of health in the state of  
20 Louisiana where I supervised public health -- or had  
21 direct responsibility for public health, for mental  
22 health, for persons with developmental disabilities  
23 and for regulation oversight of all hospital and  
24 mental health institutions.

25 And then from there I was the president of the

1 Florida group for a hospital company. I operated 23  
2 hospitals in Florida.

3 And then moved up here in January of 2014 to  
4 take on this role as CEO of Mountain States.

5 Q. And as the CEO of Mountain States, what are  
6 your daily job duties and obligations? What keeps you  
7 up at night?

8 A. Well, my fiduciary -- well, there's a lot that  
9 keeps me up at night. My fiduciary responsibility,  
10 obviously, to the board is to ensure a sound strategy  
11 for the system, to hire the right people, to, you  
12 know -- both in the near-term and in the long-term  
13 view, to position Mountain States to best serve the  
14 needs of the community. It's a not-for-profit system  
15 that has unique obligations in that region as the  
16 largest provider of health services in the region.

17 What keeps me up at night, primarily, is it's  
18 a very difficult region in terms of the health status  
19 of the population. There's some very sick people  
20 there. And it's not an urban area, so attracting  
21 physicians and services and retaining them and then  
22 being able to provide a good coordinated set of  
23 services is the daily challenge.

24 Q. And what -- if it's helpful, there's a map  
25 there over your shoulder, but -- that shows sort of

1 the psychiatric providers in this area, but just --  
2 we'll talk about psychiatric in a moment.

3 What facilities and services does Mountain  
4 States offer to the region as depicted on that map?

5 A. Well, we have 13 hospitals that range  
6 everything from having the regions only children's  
7 hospital in Johnson City to acute care. We have a lot  
8 of rural hospitals that are in very underserved areas.

9 We have a variety of services, from a mobile  
10 diagnostic unit to radiation oncology to we have  
11 intensive outpatient placement programs in some of  
12 the rural areas that are very underserved for mental  
13 health.

14 We have virtually every service except  
15 for transplant and a burn unit. We try to be as  
16 accommodating to the multiple needs of the community  
17 as we can be.

18 Q. And you spoke, I think, about Niswonger  
19 Children's Hospital, and is that a department or  
20 connected with Johnson City Medical Center in Johnson  
21 City?

22 A. It is a department of -- it's a freestanding  
23 facility attached to Johnson City Medical Center and  
24 it's a department of Johnson City Medical Center.

25 Q. And as a nonprofit and as the community

1 provider in this area, what obligations do you feel  
2 that Mountain States has to the TennCare population  
3 and the underserved population in this area?

4 A. Well, I think it's an enormous obligation  
5 and it's one that we have a long history of doing.  
6 This year we'll provide \$40 million of uncompensated  
7 Medicaid, Medicaid shortfall, about 20 million in  
8 charity, another 12-or-so million in direct services  
9 for people that are not funded, about 90 million in  
10 community benefit that, according to the IRS, is --  
11 we use the IRS guidelines for accounting community  
12 benefit -- about 90 million. So it's something we  
13 take pretty seriously.

14 You know, we invest our margin back into  
15 our system, and we can -- I could certainly point  
16 to strong evidence of that. We invest heavily,  
17 particularly in areas that are underserved, where  
18 there's not alternatives or other forms of access.

19 Q. Speaking specifically on the psychiatric  
20 side, does Mountain States offer psychiatric services  
21 through some of its facilities?

22 A. Yes, sir. We have a variety of access points,  
23 Woodridge being the primary -- well, the inpatient  
24 access point. You know, trying to keep in line with  
25 where mental health is evolving, we're trying to push

1 more out into the communities. And particularly for  
2 people that are uninsured or on Medicaid, TennCare  
3 or, in Virginia, Medicaid, we're trying to bring  
4 access to them as opposed to them having to come to  
5 us.

6 The evidence shows that kind of inpatient  
7 services in mental health is sort of the last resort  
8 or should be the last resort, and so because of that,  
9 we're trying to push more into those regions.

10 So, for instance, at Johnson County Community  
11 Hospital up in Johnson County, which is about a  
12 45-minute drive to any hospital, we have intensive  
13 outpatient programs there for mental health. We have  
14 some intensive outpatient programs, I believe, at  
15 Dickenson. We've got geriatric site programs in  
16 Elizabethton. We're standing up some programs at  
17 Russell County.

18 So we're trying to -- we're working, actually,  
19 with Frontier right now, which is a service provider  
20 in the region, to stand up a crisis center for  
21 adolescents, again, to try to divert people from the  
22 inpatient setting and to try to bring services closer  
23 to where they live, in particular, because -- and why  
24 I think that's so important is the people that are  
25 uninsured or on TennCare or Virginia Medicaid have

1 less resources to be able to travel to those services.

2 Q. There's some comments of yours that were  
3 brought up earlier in this proceeding that discussed  
4 that Northeast Tennessee and Southwest Virginia  
5 disproportionately suffer from mental health issues.  
6 Is that true in your belief?

7 A. I believe it's true and I think the evidence  
8 points to it, and so yes.

9 Q. And the comments that were selected I don't  
10 think necessarily encompassed all the comments that  
11 you were making as part of those public announcements  
12 of the potential merger between Mountain States and  
13 Wellmont. What was the whole message that you were  
14 trying to convey as part of those comments?

15 A. Just to be clear, I have never once said  
16 that we need to build more inpatient beds or that  
17 the future of what we want to do is to build more  
18 inpatient capacity. What I've articulated clearly,  
19 in fact, is to the contrary, that, you know, by --  
20 the context of what I was asked was, you know, in  
21 the context of the proposed merger and some public  
22 comments I made in the newspaper.

23 And clearly what I said was that, you know, by  
24 collaborating together, you can reduce, ultimately,  
25 the need for inpatient hospitalization, therefore

1 reducing costs and bringing services closer to where  
2 people live in the community.

3 And so the context of what I've said has been  
4 very consistent all along, publicly in the newspaper  
5 and to any group I've talked to. We want to drive use  
6 rates down the right way by ensuring those alternative  
7 services are available in those communities, and  
8 that's what -- that was the context of what I said as  
9 it related to the proposed merger between Mountain  
10 States and Wellmont.

11 Q. And does Mountain States perform community  
12 health assessments?

13 A. Yes.

14 Q. And did you recently publish new health  
15 assessments just in the last six weeks or so?

16 A. Yes. Those are very instructive for us as  
17 we build our strategic plan. Again, as a community-  
18 based, not-for-profit organization, obviously the  
19 balance sheet's very important, but we have to drive  
20 our strategy based on what the needs of the community  
21 are.

22 Which, you know, having run, at a senior  
23 level, a for-profit hospital company, I understand  
24 that there's different fiduciary responsibilities  
25 here. As a community-based organization, our

1 fiduciary responsibility is to make sure we're  
2 addressing the community need whether we get paid  
3 for it or not.

4           And so, you know, for instance, we ask -- and  
5 we go to great lengths to inquire of people from  
6 throughout the region -- what are the needs of your  
7 community based on your assessment? And these are  
8 people who are fairly expert in the region. And we  
9 use that information to craft, you know, the services  
10 that we want to grow and offer.

11 Q.       A couple of those community health assessments  
12 have been made exhibits to this proceeding, one that  
13 evaluated Sullivan County and one that evaluated  
14 Washington County. Based on your review of those  
15 documents, did anyone, any stakeholder in either of  
16 those communities, Sullivan County or Washington  
17 County, Tennessee, ever communicate to you-all during  
18 your assessments that there was a need for a new  
19 72-bed inpatient hospital for psychiatric services?

20 A.       No.

21 Q.       And is Mountain States currently taking steps  
22 through things like mental health task force to make  
23 sure that you-all are meeting the needs of the  
24 community as it relates to psychiatric services?

25 A.       Yes. In fact, as part of our process for

1 evaluating the proposed merger, together with  
2 Wellmont, we announced recently four task forces to  
3 look at research and academics is one; two, mental  
4 health and addiction, which we know is a unique issue  
5 in our -- I shouldn't say unique. It's a serious  
6 problem in our region. It may not necessarily be  
7 unique to our region, but I think we're one of the  
8 few communities that has the privilege of having this  
9 problem to the degree we do.

10 Long-term access and services for children,  
11 and child and family health. And the fourth one  
12 was population health, you know, evaluating how to  
13 collaborate to change -- or to address what are the  
14 causal variables for health outcomes in our region and  
15 then to develop a ten-year strategy for addressing,  
16 for instance, teen smoking: What are the variables  
17 that drive teenagers to smoke? What are the variables  
18 that drive kids to self-medicate.

19 And so those four task forces are charged --  
20 in fact, the mental health task force is being led by  
21 the CEO of Frontier, and the point is to address what  
22 are the gaps where we can bring more community-based  
23 services to those communities where they're needed.  
24 And our plan would be to invest synergies from the  
25 merger into addressing those needs.

1 Q. Yesterday we heard from Dr. Debbie Collier,  
2 a health planning expert, and she has opined that if  
3 this project is approved that there would be a 1.5 to  
4 \$2 million impact on Woodridge's bottom line by Year 2  
5 of the project in her conservative estimation.

6 If she's right about that and that impact  
7 comes to fruition if this application is approved,  
8 what would that mean to Woodridge and what would that  
9 mean to Mountain States?

10 A. Well, I think it has a lot of meaning to us,  
11 and I think you have to look at it in the context of  
12 our balance sheet. You know, we currently carry about  
13 \$1.3 billion of liability. About 1.1 billion of that  
14 is long-term debt and about 200 million of it is  
15 short-term liabilities.

16 If you look at our cash flow, I mean, we have  
17 a cash flow of \$150 million a year. About 70 million  
18 is debt service. It's easy to draw a conclusion that,  
19 you know, the difference between the debt service and  
20 the cash flow means we have a lot of money, but the  
21 reality is, if you look at the last -- you have  
22 another expense item called a depreciation, which runs  
23 about 70 million a year for us. Depreciation is what  
24 you're supposed to spend on capital. That's why  
25 you're given tax benefits for having depreciation

1 expense if you're an investor-owned.

2 You know, in the last six years, we've  
3 averaged \$115 million of capital expenditures per  
4 year. So we're spending -- over the last six years,  
5 each year we have spent about 30 million more than our  
6 cash flow, recapitalizing and servicing our debt.

7 And so the context of this is if you look at  
8 the balance sheet and our debt service ratios, we're  
9 triple-B-plus rated, which is, I believe, at the  
10 bottom rung of investment grade bonds, because of our  
11 debt. And I'll talk about our debt in a minute and  
12 the reason for it.

13 But if you look at the debt ratio -- there are  
14 ratios exclusive to the cash flow. If you look at the  
15 ratios, our debt service coverage is about 2.3. The  
16 median for triple-B-plus is 3. So we're below the  
17 median for the rating category we're in. Our debt  
18 to cap -- our debt to capitalization is roughly  
19 57 percent, I believe. The median, I want to say, is  
20 in the 40s. I think -- I'd have to confirm that.

21 Q. Does 44 sound about right?

22 A. Yes, that sounds about right.

23 Our cash to debt is roughly 65 percent, and I  
24 think the median is in 80s. And so we're below the  
25 bond rating medians for our triple-B-plus category.

1 The thing that keeps us a triple-B-plus is our cash  
2 flow. And any threat to that cash flow, it becomes  
3 a challenge in terms of sustaining our bond ratings.

4 And so, you know, it's -- and, by the way, I  
5 know that it's easy to articulate that because we have  
6 150 million cash flow, "Well, what's a couple million  
7 dollars?" Well, as I've articulated, there's not  
8 fluff there. The depreciation expense we exceed by  
9 a substantial margin each year recapitalizing.

10 What are we doing with that capital? In Smith  
11 County, Virginia, they had access issues with the  
12 hospital there. We acquired that hospital and built a  
13 new one. We just built a new hospital in Abingdon.  
14 We're building a new hospital in Unicoi, Tennessee, a  
15 rural area. That hospital literally ran out of money,  
16 and we cash flowed \$4 million to that hospital to keep  
17 it open before we even took ownership of it, and we're  
18 building a new hospital there to sustain that access  
19 point. So we're investing capital where we believe  
20 it's necessary to create sustainable access points for  
21 those communities.

22 Again, if those points go away, it will  
23 put enormous pressure on other hospitals and other  
24 physician communities and, frankly, it's not good for  
25 the people who are uninsured or on Medicaid who don't

1 have the means to be able to travel to those services.

2 So a couple million dollars does have meaning  
3 to us. It's not just some small amount of money. And  
4 when you lose -- when you have that kind of an impact,  
5 you have to figure out how you're going to offset  
6 that, you know, there's other services we also provide  
7 that would then require us to go look at, in terms of  
8 their cost structure, to offset that loss of revenue.  
9 So I think it's a big deal.

10 One other thing, when you talk about the  
11 potential loss of the commercial volume from  
12 Woodridge, that's not immaterial. I mean, the numbers  
13 I've seen are somewhere about a thousand cases that we  
14 could lose relative to this potential new facility.  
15 And the overwhelming majority of that, based on the  
16 data I've seen, is commercial-paying business.

17 And the concern I have about that is, you  
18 know, that's going to end up driving up the variable  
19 costs for the programs that we -- what happens is  
20 what's left behind -- see, I think the 2 million is  
21 conservative, because what's left behind is -- a lot  
22 of times physicians provide services in hospitals  
23 because they're able to bill and collect for those  
24 services. If the commercial volume goes away and  
25 we're left with the uninsured and Medicaid, we then

1 have to subsidize the lost revenue for the physician,  
2 which ends up driving up the variable costs of  
3 providing those services in that hospital.

4 And there's a point where with the competing  
5 capital demands that we have and the competing  
6 services that we have need for, at some point there's  
7 a need to be fiscally responsible with our resources  
8 and decide, well, this is not necessarily what we need  
9 to invest in anymore and we need to move our resources  
10 over here, perhaps to the children's hospital or  
11 something else. So I was disturbed to hear it  
12 minimized as it's only a couple million dollars. It  
13 is more than just a couple million dollars.

14 Q. And it might be self-explanatory, but if the  
15 bond rating for Mountain States were to be downgraded,  
16 what would the financial result of that be for  
17 Mountain States?

18 A. Several million dollars a year in additional  
19 interest payments.

20 Q. And part of the capital expenditures you were  
21 describing, have some of those capital expenditures  
22 also been earmarked for Woodridge?

23 A. Yes.

24 Q. And if a \$2 million loss were to hit  
25 Woodridge's bottom line, what impact would that have

1 on your ability to sustain infrastructure improvements  
2 to Woodridge Hospital?

3 A. Well, again, you have to -- when you're  
4 deciding on spending capital, there's a lot of factors  
5 that you consider. One of them is, you know, are  
6 you -- Woodridge has needs. The children's hospital  
7 has needs. The cancer program has needs. The trauma  
8 service, which we subsidize, has needs.

9 At some point, when you're having this  
10 competition for limited capital -- there's not  
11 unlimited resources -- you end up having to decide  
12 and prioritize where you're going to spend that money.

13 And if you have a service that's going to  
14 continue to lose money and your variable costs may  
15 continue to grow, you just -- at some point you have  
16 to make some tough decisions, and that would be a  
17 problem.

18 When you step back and look at the -- just the  
19 service offerings that we do, we have Woodridge right  
20 there. It's right there near the children's hospital.  
21 Washington County is the only county that has a  
22 growing pediatric population. The other county,  
23 Sullivan, has, I think, a projected 20 percent decline  
24 in the pediatric population. So there's other impact  
25 to the coordination of these services when you end up

1 disrupting a service like you have at Woodridge, so --  
2 in particular for children.

3 MR. SWEARINGEN: That's all the questions  
4 I have, Your Honor. Thank you.

5 MR. WEST: If I may, Your Honor.

6 CROSS-EXAMINATION

7 BY MR. WEST:

8 Q. Mr. Levine --

9 A. Good morning.

10 Q. -- good morning. You and I met around May  
11 27th --

12 A. Yes, sir.

13 Q. -- when I took your deposition.

14 A. Yes, sir. Good to see you again.

15 Q. Good to see you. I'm Bill West representing  
16 SBH-Kingsport. Some of your testimony today raises  
17 some questions I'd like to ask you as far as our side  
18 is concerned.

19 First of all, you had mentioned just in the  
20 last few minutes scheduling what you call capital  
21 expenditures for Woodridge or anticipating some  
22 capital expenditures at Woodridge. What are those?

23 A. We've approved some capital for the intake  
24 area, to renovate the intake area. We've approved  
25 some capital to do some roof work, the outside fence

1 area where the play area is and the break area, mostly  
2 -- a lot of cosmetic and some infrastructure.

3 Q. But no new beds?

4 A. No.

5 Q. Okay.

6 A. I mean, hold on. In the currently approved --

7 Q. I mean additional beds.

8 A. In the currently approved, what I've approved  
9 and what our board has approved, no, there's no  
10 additional beds.

11 Q. Is there any long-term plan to add beds at  
12 Woodridge?

13 A. At the current time, no.

14 Q. Well, has there ever been, in the recent --  
15 since you've been there?

16 A. Well, we haven't seen the need at this point.  
17 As with any service, we evaluate based on what the  
18 need is, and if there was a need of a few more beds,  
19 then we would do what was appropriate to address that  
20 need. Of course, what we're trying to do is divert  
21 the need for additional beds throughout outpatient  
22 expansion.

23 Q. I understand. But my question was: Have you  
24 seen any plans, since you've been at Mountain States,  
25 that called for additional -- or planned for

1 additional beds at Woodridge?

2 A. No.

3 Q. Okay. A lot of the testimony in this case  
4 has -- that we've heard over the last few days has  
5 concerned something called a crisis stabilization unit  
6 for adolescents that's proposed to be developed in  
7 Washington County. Are you familiar with that?

8 A. Yes, sir.

9 Q. Have you been involved in the negotiations in  
10 that?

11 A. No, sir.

12 Q. Who at Mountain States would be in charge of  
13 that?

14 A. Well, we have management. Multiple people  
15 have been involved in that, I'm certain. I don't know  
16 specifically who was meeting with Frontier to do the  
17 specific negotiations. We have service line leaders  
18 who do that.

19 Q. So you, yourself, have not been involved?

20 A. No.

21 Q. What is your understanding of the structure of  
22 a proposed adolescent CSU?

23 A. What little I know about the details, my  
24 understanding is Frontier -- it's a partnership  
25 between us and Frontier. Frontier will operate it.

1 They're our key primary outpatient partner. And we'll  
2 have a very tight coordination between the CSU and  
3 Woodridge and potentially all the ERs in the region as  
4 children present.

5 Q. It's for adolescents and not children, right?

6 A. Correct. Yes.

7 Q. I would consider them children, but  
8 technically they're called adolescents.

9 A. Thank you for correcting me.

10 Q. And is it your understanding or anticipation  
11 that once the adolescent CSU goes into operation in  
12 Gray, Washington County, that the adolescent patient  
13 volume at Woodridge will decline?

14 A. I hope so.

15 Q. So it's your intent for it to fall?

16 A. Uh-huh.

17 THE COURT: You need to say yes or no for  
18 the record.

19 THE WITNESS: Yes. Thank you.

20 BY MR. WEST:

21 Q. And if the adolescent volume at Woodridge  
22 falls, will that have any fiscal impact on Woodridge?

23 A. It could.

24 Q. Because, by and large, it's true, isn't it,  
25 that the adolescent patients seen at the child and

1 adolescent unit at Woodridge are Medicaid -- Medicaid  
2 is the payment source, generally, for those patients,  
3 correct?

4 A. Yes.

5 Q. So Woodridge would lose at least some Medicaid  
6 patients to the CSU once it goes into operation?

7 A. I would suspect that would be correct.

8 Q. And that will have a financial impact on --  
9 that will have an impact on the financial results at  
10 Woodridge, would it not?

11 A. It will have a financial impact. I can't tell  
12 you what that financial impact is. Medicaid does pay  
13 below our cost, but it would have --

14 Q. I'm sorry. I didn't quite understand your  
15 last comment. Medicaid does what?

16 A. Medicaid pays below the full cost of care,  
17 just like the grant program does. So it would have an  
18 impact, but I -- well, you can ask your next question.

19 Q. We've also heard discussion about or an  
20 analysis of a concept called contribution margin by  
21 case.

22 A. Uh-huh.

23 Q. Do you understand what that is?

24 A. Yes, sir.

25 Q. And is that something that you or your

1 financial staff monitor at Mountain States?

2 A. Mostly our financial staff does, but I  
3 obviously keep my eye on it.

4 Q. Yes. So if I understand what's been  
5 presented, speaking as a lawyer, about a contribution  
6 margin, it essentially measures the impact -- the  
7 financial impact of the loss of a case.

8 For example, you have a positive financial  
9 margin of \$1,000 or capital contribution, whatever  
10 you want -- financial margin, then if you lost that  
11 case -- it went somewhere else -- that would be a  
12 \$1,000 net loss?

13 A. There's a fundamental -- I don't -- there's a  
14 fundamental difference in what we're talking about  
15 here.

16 Q. Okay.

17 A. There's a difference between a patient not  
18 being admitted and us not getting the revenue because  
19 there's an alternative service that's a lower cost and  
20 more available in the community versus losing the  
21 revenue because there's a duplicate program being  
22 added. There's just a difference.

23 And so here's my concern. If you have  
24 an impact to the contribution margin because an  
25 incremental number of children -- or adolescents are

1 not admitted because they went to outpatient  
2 treatment, I view that as a good thing. If you have  
3 loss of margin at the -- frankly, at the level we're  
4 talking about, with duplication of inpatient beds,  
5 that contribution margin is going to get worse because  
6 the variable cost of what remains is going to go up.  
7 You then have to start subsidizing physicians for the  
8 lost revenue from the commercial business. And so the  
9 magnitude is very different than what we're talking  
10 about.

11 Q. When you speak of difference, you're speaking  
12 of a difference in magnitude?

13 A. Yes.

14 Q. But is it true that there will be -- I mean,  
15 I've asked you this question several times, I guess,  
16 but you don't disagree with the concept that if  
17 80 percent of your adolescent business from Frontier  
18 gets handled by the adolescent CSU, those patients  
19 will not be billed for by Woodridge?

20 A. I don't agree with the 80 percent, but the  
21 concept, I believe, is correct, yes.

22 Q. Have you seen any projections of how much that  
23 will -- what the number of adolescents -- how the  
24 adolescent volume at Woodridge will be affected by the  
25 adolescent CSU?

1 A. I've seen it, but I don't remember the  
2 percentage.

3 Q. Was it large or small?

4 A. I don't remember.

5 Q. When I took your deposition, I believe we had  
6 some questions and answers about -- let me backstep.

7 In your prior answer here today, you talked  
8 about if the patients that are, quote, lost to  
9 Woodridge because of the CSU -- they go to the CSU --  
10 you consider that an outpatient service?

11 A. I consider it an alternative setting for,  
12 hopefully, diversion of adolescents to services that  
13 are closer to where they live, that are community-  
14 based, should the services be available. I don't  
15 think it will eliminate the need for inpatient  
16 admission for all of them by any means.

17 Q. But my question was more the nature of the  
18 care at the CSU, for example. I mean, you would agree  
19 that the regulations for adult CSUs currently talk  
20 about a three-day length of stay, generally?

21 A. I don't know what the regulations are.

22 Q. But my point is they stay overnight. It's not  
23 like they go -- I mean, they don't go there and just  
24 go home.

25 A. Understood.

1 Q. So, in that sense, they're inpatient, although  
2 it's not hospital inpatient?

3 A. Correct. It's primarily observational and to  
4 begin to do a proper assessment to get them properly  
5 placed.

6 Q. And what is the -- what is Mountain States'  
7 role going to be in the adolescent CSU?

8 A. I don't know the specifics. I think primarily  
9 it's to have Frontier provide the actual frontline  
10 service, but clearly, as the major inpatient facility,  
11 plus with the children's hospital and with the ERs  
12 that we have in that community, there's going to be a  
13 need for incredible coordination. And I think that's  
14 probably the extent of it, but I don't know for sure.

15 Q. You had mentioned a partnership, but my  
16 understanding is what you mean by partnership is more  
17 the sort of social aspect of the organization but not  
18 a legal partnership in the actual CSU itself.

19 A. Right. Primarily it will be Frontier's  
20 program with us providing support and help.

21 Q. But you won't be sharing in whatever revenues  
22 Frontier -- you won't be sharing directly in whatever  
23 revenues Frontier receives?

24 A. I don't believe we will be.

25 Q. And I guess you've been up in Johnson City for

1 a while, but you've been made aware of the scope and  
2 history of Frontier as part of this process you've  
3 discussed, in analyzing needs and so forth?

4 A. I don't know what you mean by scope. I've  
5 heard some history, but I don't know the depth of...

6 Q. Well, it's true, isn't it, that Frontier has  
7 offices all over the Upper East Tennessee and  
8 Southwest Virginia area, correct?

9 A. Uh-huh. Yes.

10 Q. And so you know Dr. Jessee?

11 A. Yes.

12 Q. And he testified here earlier in this week,  
13 and he indicated that, I believe, they saw -- I don't  
14 know exactly how he described it, but 40,000 patients,  
15 roughly, last year. Would that surprise you?

16 A. I have no --

17 Q. Or do you disagree with that?

18 A. I have no basis to answer that.

19 Q. Well, my question to you is: Is it true that  
20 Frontier covers a wide service area?

21 A. I believe that's correct.

22 Q. And is it true that they have a multitude of  
23 offices -- that's the wrong word. Is it true they  
24 have many offices across the region, for example, in  
25 Kingsport, in Johnson City, in Gray, up in Virginia in

1 Wise, Scott, and Lee and those types of counties, they  
2 have offices or representation all around?

3 A. I believe they have a geographic  
4 representation. I don't know exactly where they are,  
5 but I believe that to be correct.

6 Q. And you said yourself that the goal is to move  
7 the services out closer to where the patients are; is  
8 that correct?

9 A. Yes, sir.

10 Q. That's your goal and Mountain States' goal?

11 A. I think it's -- I think it's collectively the  
12 mental health community's goal, and we certainly  
13 support that.

14 Q. And my question is: Frontier is already out  
15 there in all those counties, is that correct, at their  
16 office wherever they are?

17 A. Frontier is where Frontier is. When you say  
18 "all the areas," I don't know that that's an accurate  
19 statement.

20 Q. Right. But you don't dispute that they're  
21 in many places in your service area, in Upper East  
22 Tennessee and Southwest Virginia?

23 A. I don't dispute that, no.

24 Q. Okay. And if they are in many of those places  
25 and having 40,000 patients a year, they are delivering

1 a pretty significant volume of services. Would that  
2 be your understanding?

3 A. I suspect it varies by office, but generally,  
4 yes. I would hope that they would be busy providing  
5 those services wherever they're located.

6 Q. You don't know of any reason to disagree with  
7 Dr. Jessee's comments about the volume of services  
8 they provide?

9 A. Yeah, I would have no basis to do that.

10 Q. And so since Frontier is out there providing  
11 services in many offices across Northeast Tennessee  
12 and Southwest Virginia, what additional services do  
13 you foresee being provided by Mountain States or  
14 Mountain States and Wellmont after the COPA? Can you  
15 describe those?

16 A. Well, I think part -- that's part of why we  
17 have the needs assessment that we're doing, that's  
18 ongoing right now. And, again, we wanted to be  
19 informed by what the experts in the region -- and I  
20 mean throughout the region, the Southwest Virginia  
21 region and Northeast Tennessee, all in -- we need to  
22 know based on the pockets of population throughout the  
23 region what are the needs. They're going to be  
24 different in different communities.

25 Q. I understand.

1 A. And so that will inform where we make those  
2 investments.

3 Q. And what types of investments are you  
4 contemplating?

5 A. I won't know until the experts tell us where  
6 the investments need to be, but I can -- I can assume  
7 that there's going to be a lot of focus on what we do  
8 about addiction, to prevent addiction or to prevent  
9 the recurrence of addiction. I suspect there will  
10 be -- you know, I don't want to guess, because it --  
11 what's not been done is a good baseline of what are  
12 the needs.

13 And I'm very hesitant to displace the  
14 knowledge of that information with a presumption  
15 that just building more inpatient beds solves these  
16 problems. And so we want to be guided by the actual  
17 facts and the data much like the needs assessments  
18 that we do in the communities but at a much more  
19 detailed level.

20 And our plan is to actually have ETSU, East  
21 Tennessee State University, conduct -- these task  
22 forces are going to do their work. ETSU is going to  
23 be doing a very deep-dive, analytics-driven population  
24 health needs assessment, and that will inform what the  
25 actual needs in that region are.

1 I will say I believe the doubling down on  
2 inpatient capacity without considering those things is  
3 potentially going to fragment what we're trying to do.  
4 Putting adolescent and children services in Sullivan  
5 County where you actually have a declining population  
6 for children and adolescents while Washington County  
7 has actually seen a growth in children and  
8 adolescents, it's just going to -- in my view, it's  
9 going to fragment it more, as opposed to letting the  
10 results of these analyses tell us and inform us what  
11 services we need to add, and, again, with the goal  
12 being to reduce inpatient utilization.

13 Q. I understand your answer, but is it true that  
14 the CSU for adolescents that has been proposed is in  
15 Gray in northern Washington County?

16 A. It's a fairly halfway point between Washington  
17 County and Sullivan County, towards Kingsport, I  
18 believe.

19 Q. Well, there's only one line between Washington  
20 County and Sullivan County. You mean closer to  
21 Kingsport than to Johnson City?

22 A. I don't know the exact location, but Gray  
23 is -- may I point to the map?

24 Q. Sure. That's fine.

25 A. Gray is going to be closer up here than here

1 (indicating).

2 Q. So you're indicating an area pretty close to  
3 the Sullivan/Washington County line?

4 A. I believe so.

5 Q. So you're moving adolescent utilization out  
6 of the hospital and putting it closer to Sullivan  
7 County -- not you, but adolescent utilization for  
8 those types of services will be moved out of Johnson  
9 City and closer to Sullivan County if the adolescent  
10 CSU goes forward?

11 A. Well, about 25 percent of the services that we  
12 provide at Woodridge come out of Sullivan County, so  
13 we do want to make sure it's accessible for the  
14 families and their kids.

15 Q. Even though you just testified that the  
16 relative level of children among the population is  
17 higher in Washington County than Sullivan County?

18 A. Gray is pretty darn close to Johnson City, so  
19 let me -- I don't want to -- I hate for it to be  
20 characterized like we're moving it -- we're talking  
21 about a five- to ten-minute difference.

22 Q. You had mentioned Mountain States in your  
23 prior testimony, Mountain States' acquisition -- I'll  
24 call it acquisition of the Unicoi County Hospital.  
25 And that occurred about two years ago, 18 months ago?

1 A. I believe it closed in November of 2013.

2 Q. All right. What was the cost to Mountain  
3 States for that acquisition?

4 A. I don't know the number of -- I don't believe  
5 that there was a cost of acquiring. I believe there  
6 was an agreement to provide working capital because  
7 they were out of money.

8 Q. Uh-huh.

9 A. And I believe that working capital was around  
10 \$4 million to keep the doors open. And I believe  
11 there was a contribution to the community of -- and I  
12 don't know the exact amount -- I want to say it was  
13 either 1- or \$2 million to the community to use for  
14 public health resources.

15 Q. And Mountain States also committed to build  
16 essentially a replacement hospital in Unicoi County?

17 A. Yes, sir. Yes.

18 Q. Because that had been, essentially, the county  
19 hospital?

20 A. I don't know the structure, but I do believe  
21 the hospital is owned by either the county or the  
22 city, and we lease the existing asset from them.

23 Q. I know that Mountain States, then, has made  
24 a pretty significant investment in Unicoi, is that  
25 correct, Unicoi County?

1 A. Can you define what you mean by "investment,"  
2 "pretty significant investment"? Are you talking  
3 about what we've already put into it or the plan to  
4 build a new hospital?

5 Q. I'm talking about all of it.

6 A. Okay. Yes. I would call that sizable.

7 Q. When Mountain States was pursuing -- pursuing  
8 is the wrong word -- was contemplating that  
9 acquisition -- and the county hospital had some  
10 difficulties, I understand, but there was another  
11 bidder, another nonprofit bidder for that hospital,  
12 was there not?

13 A. I wasn't here, but based on what I heard, yes.

14 Q. And that was Wellmont?

15 A. That would be the one I heard.

16 Q. Yeah. Okay. And as a matter of fact, the  
17 initial effort by Mountain States to acquire the  
18 hospital was initially denied by the Attorney General;  
19 is that correct?

20 A. I don't know.

21 Q. So you weren't --

22 A. I wasn't here.

23 Q. Okay. But my point is: It wasn't necessary  
24 for Mountain States to acquire Unicoi in order for  
25 Unicoi to continue in operation because Wellmont could

1 have acquired it?

2 A. It was my understanding Wellmont withdrew.

3 Q. Well, but there was a bid process, right, that  
4 Wellmont did participate in?

5 A. I believe that's correct, but I think, at  
6 the end, my understanding was, to a lot of people's  
7 surprise, Wellmont withdrew from the process. There  
8 were supporters that -- again, this is not my  
9 firsthand knowledge, but my understanding was there  
10 were some supporters of Wellmont that were extremely  
11 surprised when Wellmont withdrew.

12 Q. But you don't know at what point in the  
13 process Wellmont withdrew, do you?

14 A. No, I don't.

15 Q. And you do know Wellmont, at some point, was  
16 involved in the bidding process; is that correct?

17 A. Yes. Yeah.

18 Q. In response to Mr. Swearingen's questions, you  
19 were mentioning the amount of debt service coverage  
20 you have currently and so forth. Were you utilizing  
21 fiscal year-end 2015 numbers for that or was it the  
22 prior nine-month document, nine-month 2015?

23 A. Well, fiscal year 2015 is not audited. Those  
24 numbers are unaudited, so they're preliminary. But  
25 the debt service coverage is relatively static. It

1 doesn't change all that much. So it would be the same  
2 for 2015 as it was for 2014.

3 Q. All right. Is it true that Johnson City  
4 Medical Center receives a disproportionate share of  
5 dollars for additional indigent care patients?

6 A. Yes.

7 Q. And what is the source of those dollars?

8 A. Well, DSH is a federal-state program. The  
9 state -- I don't know what the state-federal match is  
10 for Tennessee, but more than half the money comes from  
11 the federal government and it's matched by the state.  
12 The state taxes the hospitals to provide the state's  
13 funding, the state's match. So we pay basically the  
14 state's portion. They draw down the federal money and  
15 then the money comes back to the hospitals.

16 Tennessee has the distinction of being the  
17 worst funded DSH state in the country. I think the  
18 whole state gets about 80 million or somewhere in that  
19 range, so it's a very small amount, but we do get some  
20 of it.

21 Q. And does Johnson City -- let me ask you the  
22 question for Johnson City Medical Center. The money  
23 that is allocated to it from the DSH, I believe is how  
24 it's -- D-I-S-H is how it's -- D-S-H --

25 A. D-S-H, disproportionate share hospital.

1 Q. Those funds, do those cover the indigent  
2 patients seen at Woodridge?

3 A. I don't know the breakout of how the funds are  
4 applied. I think it's just a general pot of money  
5 that we're allocated, and there's some formula that's  
6 used. I can't be specific about it.

7 Q. But you don't dispute the fact that Woodridge  
8 is a satellite of Johnson City Medical Center?

9 A. It's actually on the license of Johnson City  
10 Medical Center.

11 Q. Earlier in your testimony here -- I want  
12 to make sure I understand it correctly -- you made  
13 a comment -- I think it was in response to one of  
14 my questions -- that Medicaid has a lower -- I'm  
15 rephrasing it a little bit, but my understanding was  
16 Medicaid reimburses the hospitals, such as Johnson  
17 City Medical Center or Woodridge, with reimbursement  
18 lower than the actual cost of delivering the service?

19 A. I'm sorry. Can you ask that one more time?

20 Q. Medicaid reimbursement --

21 A. Yes.

22 Q. -- does it cover the cost to Woodridge of  
23 delivering services to a Medicaid patient?

24 A. No.

25 Q. And so does receiving a -- does an incremental

1 Medicaid patient whose costs are not covered, does  
2 that -- let me back up.

3 MR. WEST: Let me rephrase, Your Honor.

4 BY MR. WEST:

5 Q. So if Woodridge -- if a patient, a Medicaid  
6 patient that would otherwise go to Woodridge went to  
7 the CSU, adolescent CSU, for example, wouldn't that be  
8 a positive net impact for Woodridge, given that it  
9 wouldn't suffer the reimbursement less than the cost?

10 A. It's a very complex issue, because it's --  
11 you're on both ends of the sword here. On the one  
12 hand, if you do lose money on a Medicaid patient and  
13 the Medicaid patient doesn't come, then certainly  
14 you've reduced your loss. On the other hand, your  
15 Medicaid days are part of what drives your DSH and  
16 essential access payments.

17 So on the plus side, you may have a lower  
18 incremental cost. On the down side, you lose the days  
19 that help you generate the funding that serves to help  
20 compensate for the shortfall in Medicaid and charity  
21 and uninsured. So it's a pretty complex formula. So  
22 I can't tell you what the benefit or cost is here, but  
23 there is an impact.

24 Q. And do you know whether it's positive or  
25 negative?

1 A. I can't say. I can say from a policy  
2 standpoint, if we can avoid a child being held as an  
3 inpatient in a hospital, that's our preference.

4 Q. So, if I may, I wanted to recount, because  
5 we're establishing a record here, that Woodridge gets  
6 money -- gets reimbursement from the state -- or gets  
7 payments from the state for -- there's a grant, a  
8 contract between Mountain States and the mental health  
9 department that's approximately \$2.6 million a year  
10 that covers a certain number -- a certain amount of  
11 dollars for patients who fall into the categories  
12 covered by the grant. That's one source, right?

13 A. Yes, sir.

14 Q. And then there's the DSH payment that you  
15 referenced earlier that flowed through Johnson City  
16 Medical Center, and some may get allocated to  
17 Woodridge as well; is that correct?

18 A. I don't know. I don't know how it's done.

19 Q. And then there's the essential access funds  
20 that you just mentioned. Is that a separate source of  
21 revenue?

22 A. Yeah. Again, Johnson City Medical Center  
23 is a teaching hospital. It's a very big, complex  
24 hospital that has, I mean, phenomenal costs related  
25 to academics and teaching, residencies. You know,

1 we're a very large provider for charity and uninsured  
2 not just in mental health, but we have the region's  
3 only children's hospital and the trauma -- we have  
4 the region's major Level 1 trauma program. And all  
5 of these require subsidies. And so I don't want to  
6 characterize it like these payments you're talking  
7 about go -- are all syphoned off to Woodridge.

8 There's a whole bunch of programs that those help  
9 fund.

10 Q. I understand. And Johnson City Medical  
11 Center, essentially, is the flagship of Mountain  
12 States. Would that be a way to -- it's your biggest  
13 hospital?

14 A. Yes, sir. It's the region's biggest hospital.

15 Q. And it provides the most services?

16 A. Yes, sir.

17 Q. And one of the funding sources that it has  
18 also is -- does it get, essentially, federal money for  
19 graduate medical education?

20 A. Up to a cap, yes. We're funding right now  
21 anywhere from 40 to 50 residents on our own dime  
22 because we're above our cap.

23 Q. But you do receive some federal grant funding  
24 for graduate medical education?

25 A. Yes.

1 Q. All right. And does that, then, flow to  
2 ETSU's medical school in some form or fashion?

3 A. Well, yes. So for their faculty, for the  
4 supervision of the residency program and things like  
5 that, you have contracts with them to handle that,  
6 yes.

7 Q. And, for example, Woodridge, the geriatric  
8 psychiatry unit right now is served by ETSU faculty  
9 and residents; is that correct?

10 A. Uh-huh. Yes.

11 Q. So do you know whether the -- do you have any  
12 information as to whether the ETSU residency program  
13 is under investigation by its accrediting bodies, by  
14 the accrediting bodies for medical schools?

15 A. I have no knowledge of that.

16 Q. Okay. Mr. Levine, I don't mean to belabor  
17 these points, but I did want to ask you a few more  
18 questions. When I took your deposition, we had some  
19 extended question-and-answer sessions about some of  
20 the things you've talked about here today. And you  
21 talked about the scope of the activities that are  
22 planned, to some degree, post-COPA, let's say. And I  
23 want to define for the record what a COPA -- what  
24 the Certificate of Public Advantage process is, if I  
25 may. You are aware that the legislature changed the

1 Hospital Cooperation Act this year to kind of beef it  
2 up and provide more detail about the Certificate of  
3 Public Advantage process?

4 A. Yes, I am.

5 Q. And you're aware that the -- I believe it was  
6 the Department of Health has just issued emergency  
7 rules that sort of give more detail, again, about what  
8 the process is like?

9 A. Yes, sir.

10 Q. And Mountain States and Wellmont are  
11 contemplating pursuing a Certificate of Public  
12 Advantage subject to a lot of preliminary steps that  
13 still remain to be done?

14 A. Yes, sir.

15 Q. And in the process of all of that, in your  
16 deposition we had some questions and answers about the  
17 possibility -- or in your planning process for looking  
18 at the -- at more detail about the needs of the  
19 various areas of your service area, have you  
20 categorically ruled out adding any kind of inpatient  
21 beds?

22 A. We haven't discussed any of that.

23 Q. Okay. So that's still -- if your analysis --  
24 when I say "your," either yours pre-COPA or post-COPA  
25 -- determined there was a need for inpatient beds, you

1 would pursue them, wouldn't you?

2 A. Whether there was a merger or not, we would  
3 follow the need based on what the data shows us and  
4 what the input from the community is.

5 Q. Right. So if it led you to the conclusion you  
6 needed more inpatient beds, you'd pursue it, pursue  
7 those beds?

8 A. I don't want to -- I don't want to be  
9 hypothetical. I think if we're presented with facts  
10 that support it -- our last goal is to admit more  
11 people as inpatients in mental health. It should be  
12 the -- we want to provide services in the least  
13 restrictive setting.

14 So if, in the context of the plan that we  
15 establish, we can determine that there may not be an  
16 additional need -- again, if you stand up additional  
17 services, if you do things that help prevent the need  
18 for inpatient use and you know you're going to do  
19 that, then that might absolve the need for more beds.

20 And so I don't want to be hypothetical about  
21 what may or may not happen. But I can say, generally  
22 speaking, we will provide whatever services are needed  
23 for that community, and we will seek to do it in a  
24 minimal way where we're not spending resources that  
25 don't have to be spent.

1           Certainly, we don't want to -- part of the  
2 resources, incidentally, that come to help us do that  
3 are from the synergies that get created by reducing  
4 unnecessary duplication. That's the whole essence of  
5 the proposed merger, is to eliminate unnecessary  
6 duplication and then invest those synergies into  
7 things that are needed that are not currently being  
8 provided.

9           If this is done properly, you decrease  
10 unnecessary duplication, you invest those resources  
11 into things in the community-based setting and you  
12 therefore decrease the demand for the inpatient  
13 utilization. That's truly the basis and the framework  
14 for this entire discussion of a merger.

15 Q.       But, I mean, it's also true, isn't it,  
16 that Mountain States either is in the process or  
17 has recently received approval to add a few more -- or  
18 to establish a few geriatric -- geropsychiatric beds  
19 up in Dickenson County, Virginia, in the northern part  
20 of your service area?

21 A.       That's correct.

22 Q.       Okay. So in that instance, at least, new beds  
23 either have been added or will be added or possibly  
24 repurposed to geriatric psychiatric?

25 A.       That's the important distinction. We're not

1 adding beds. We're repurposing existing capacity. So  
2 you're making better use of existing capacity. That's  
3 the whole point.

4 Q. And the same thing could happen in Washington  
5 County? After you've completed your analysis that you  
6 propose post-COPA, you could possibly -- or Sullivan  
7 County either -- you could possibly repurpose beds to  
8 child and adolescent psychiatry or regular psychiatry?

9 A. I suspect that could happen.

10 Q. All right. And the community health needs  
11 assessments that you were asked about a few minutes  
12 ago now by Mr. Swearingen -- we refer to them as CHNAs  
13 -- and a number of them have just been published and  
14 put on your website at Mountain States?

15 A. Yes, sir.

16 Q. Okay. And Mountain States stands behind those  
17 as accurate documents?

18 A. Those documents are reflective of input from  
19 the community, so they're accurate from the standpoint  
20 that they reflect what we were told by the community.

21 Q. All right. And also when -- Mountain States  
22 has to annually file a 990 form with the IRS. That's  
23 a nonprofit corporation; is that correct?

24 A. Yes, sir.

25 Q. And in that 990, there's a Schedule H or some

1 schedule that talks at length or asks questions at  
2 length about the -- did you do a CHNA and have you  
3 publicized it and those types of things?

4 A. Yes.

5 Q. Okay. And so the CHNA plays a role for  
6 Mountain States because it enables Mountain States to  
7 answer "yes" to those questions on the 990?

8 A. Yes.

9 Q. And that's important for your tax exemption  
10 purposes as well? You want to -- this isn't the  
11 vernacular, but you want to keep the IRS happy about  
12 your public service at Mountain States?

13 A. We want to comply with the law, for sure.

14 Q. Yes. Okay. I wanted to cover a couple of  
15 other things. We've had discussion in this case about  
16 -- I think you, yourself, have talked about the levels  
17 of charity care provided by Mountain States. And I  
18 understand -- and I've seen it reported along the  
19 lines of what you've testified, but let me ask you:  
20 The charity care that's reported is the charges that  
21 are not made for patients who are deemed to be charity  
22 care patients?

23 A. Can you rephrase that?

24 Q. That was a little complex.

25 What is charity care, in your understanding,

1 in Tennessee?

2 A. Well, that word's used a lot and it has  
3 different meanings to different people. In my view,  
4 when I hear the words "charity care," I'm hearing  
5 "uncompensated," people who either don't have  
6 insurance, people who have insurance but they've  
7 capped out on their benefit, people who may be  
8 underinsured; in other words, they have coverage, but  
9 they don't have coverage for that specific service.

10 So, you know, different -- if you go to  
11 five different health systems, you'll get, I think,  
12 five different answers about how they account for  
13 uncompensated care. So, generally, when I hear  
14 "charity," I'm thinking those multiple pots.

15 Q. All right. Fair enough. But regardless of  
16 which pot it comes from, there is a way, and then your  
17 accountants have a way, of identifying what the cost  
18 of charity care -- however you define it, whether any  
19 of those categories or all of them, but the actual  
20 cost to Mountain States or the hospital that's  
21 reporting is; is that correct?

22 A. Yeah. There's different -- yeah, there's a  
23 methodology that's used to try to come up with costs.

24 Q. And the costs that are arrived at are  
25 significantly below -- no matter which pot it comes

1 from -- well below the actual dollars of charity care  
2 reported; is that correct?

3 A. Say that again.

4 Q. Well, let's say Mountain States reports --  
5 within all the groupings that you've specified,  
6 Mountain States identifies \$100 million, whether it's  
7 foregone charges or people who had insurance but it  
8 ran out halfway or whatever, but the cost to Mountain  
9 States' hospitals, the actual cost of delivering the  
10 care that is represented by the \$100 million is  
11 actually well -- the costs themselves are well below  
12 the \$100 million?

13 A. No. It's my understanding when we're  
14 reporting the cost of services that we're providing  
15 that it's the cost. We have a methodology for  
16 estimating the actual cost. And so there's  
17 allocations that relate to fixed cost, and then  
18 there's systems that we use to calculate what the  
19 variable cost is. So when we report, you know, 20  
20 million in charity, that's cost of charity, that's not  
21 charges.

22 Q. Okay.

23 A. Obviously, that would really inflate what it  
24 looks like. But that's an honest number, I think.

25 Q. So what do you think this year -- or last

1 year, let's say, what do you think that number was for  
2 Mountain States, the charity care cost number you just  
3 identified?

4 A. I believe it was around 20 million.

5 Q. All right. So that was -- that's what I was  
6 trying to identify. But -- okay. Fair enough.

7 MR. WEST: Your Honor, if I may have just  
8 a moment to talk with Mr. Grant.

9 (Pause.)

10 Mr. Levine, that concludes my  
11 cross-examination at this time. Thank you.

12 THE WITNESS: Thank you. Good to see you  
13 again.

14 REDIRECT EXAMINATION

15 BY MR. SWEARINGEN:

16 Q. Mr. Levine, just a couple of follow-up  
17 questions to Mr. West's questioning. He asked you  
18 about community needs health assessments that Mountain  
19 States has done and published in the last few months.  
20 Do you remember that line of questioning?

21 A. Yes, sir.

22 Q. And he asked you if you stood by those  
23 documents and what's been published. Do you recall  
24 him asking you that?

25 A. Yes.

1 Q. Those documents, do they contain maps  
2 and indications for each facility about how,  
3 administratively, you have organized and your  
4 administration team have organized your services?

5 A. I believe they do, yes.

6 Q. And just explain briefly how you've structured  
7 Mountain States' markets as reflected in those  
8 documents.

9 A. Well, you know, we have, basically, four  
10 distinctive core hospitals -- when I say "core," they  
11 tend to be the larger hospitals with our more seasoned  
12 CEOs -- Johnson City Medical Center being one; Indian  
13 Path in Kingsport; Johnston Memorial in Abingdon,  
14 Virginia; and Sycamore Shoals in Elizabethton.

15 And so just from a purely, I think,  
16 administrative function, we took the hospitals that  
17 were closest to those core hospitals and lumped them  
18 together, and the CEO of the core hospital acts as a  
19 market CEO or regional CEO for that region. It's just  
20 purely from administrative ease we're able to have  
21 hospitals that are close by be part of the same, you  
22 know, administrative function.

23 Q. And are those administrative markets that  
24 you've set up meant to be defined as service areas for  
25 Certificate of Need purposes?

1 A. No. I mean, you have to organize yourself  
2 somehow from a management standpoint, so that's how we  
3 do it. In fact, I think it would be hard to do that  
4 because there's so much crossover. I mean, for  
5 instance, the children's hospital resides in Johnson  
6 City and the market CEO for Johnson City is the CEO  
7 of Johnson City Medical Center, but the children's  
8 hospital serves the entire region, not just that area.  
9 So the word "market" is probably the wrong word to  
10 use. It's really more just a region.

11 Same thing with Woodridge, in fact. I mean,  
12 it serves a broad geographic area, so it has to --  
13 administratively, it has to fall somewhere so we have  
14 some people accountable for running it, so -- but  
15 those are not -- there's no -- believe me, beyond just  
16 the ease of administration, there was no thought to  
17 how to structure those regions or markets beyond just  
18 who's in charge.

19 MR. SWEARINGEN: No further questions,  
20 Your Honor.

21 MR. WEST: Your Honor, if I may have  
22 recross based on that.

23 THE COURT: Certainly.

24 THE WITNESS: It's like going to a tennis  
25 tournament.

1 MR. WEST: May I approach the stack of  
2 exhibits?

3 THE COURT: Yes.

4 MR. WEST: I want to make sure I have the  
5 correct exhibit.

6 Your Honor, if I may approach the  
7 witness.

8 THE COURT: Yes.

9 RECROSS-EXAMINATION

10 BY MR. WEST:

11 Q. Mr. Levine, Mr. Swearingen asked you a  
12 question about the four markets. And I wanted to ask  
13 you, in your answers, were you referring to this page,  
14 Page 4 of the CHNA -- for Johnson City Medical Center,  
15 for example, the CHNA on Page 4?

16 THE COURT: And which exhibit number is  
17 that?

18 MR. WEST: Excuse me, Your Honor. It's  
19 212.

20 THE WITNESS: I don't know what I was  
21 referring to. He asked about are there maps and then  
22 how we divide it, so I assume this is what he was  
23 referencing.

24 BY MR. WEST:

25 Q. Well, this, for example, shows that Washington

1 County is a single market --

2 A. That's correct.

3 Q. -- as you just described it. And this shows a  
4 northwest market, a northeast market and a southeast  
5 market, so that would be four?

6 A. That's right.

7 MR. WEST: Okay. All right. That's all  
8 I have, Your Honor.

9 MR. SWEARINGEN: Nothing further, Your  
10 Honor.

11 THE COURT: Mr. Levine, you can step  
12 down. I've been told you're the last witness. In the  
13 event that's changed, don't discuss your testimony or  
14 any exhibits with anyone else.

15 THE WITNESS: Yes, sir. Thank you.

16 MR. SWEARINGEN: We'd ask that Mr. Levine  
17 be allowed to return back to Johnson City.

18 THE COURT: Certainly.

19 (Witness was excused.)

20 MR. JACKSON: Your Honor, the only  
21 remaining proof by Mountain States are the two  
22 affidavits which we would tender at this time. Our  
23 opponents have made a request, as Your Honor knows,  
24 to cross-examine these individuals. So we would  
25 tender the affidavits now. If they still want to

1 cross-examine them, then what we would propose to do  
2 is to schedule a deposition, say, in the next two  
3 weeks, and we may decide -- if it's going to be video,  
4 if the cross will be video, we may decide just to go  
5 ahead and present a video direct as well.

6 It doesn't make a lot of sense to have an  
7 affidavit direct and a video cross. So we'll probably  
8 just conduct a direct examination of the witness and  
9 they can cross-examine the witness, and then we can  
10 submit that to the Court.

11 So that is what I would propose to do at  
12 this time, either submit the affidavits or, if they  
13 still want to cross-examine them, we'll schedule that.  
14 I would say it can be accomplished in the next two  
15 weeks.

16 MR. WEST: Your Honor, yes, we do  
17 want to cross-examine them. And so my assumption  
18 has been that the affidavits won't be submitted --  
19 won't enter the record until either at or after the  
20 cross-examination.

21 As Mr. Grant has indicated, we asked for  
22 cross-exam, and my understanding is that means the  
23 affidavits don't enter the record under the statute,  
24 but I'll defer to Your Honor's judgment.

25 THE COURT: Well, there's one potential

1 problem. If the affidavits are made an exhibit now  
2 and you elect to direct examine them, then we would  
3 have two pieces of testimony from the same witness.

4 MR. JACKSON: Yes, Your Honor, and  
5 maybe I wasn't clear. I was first proposing that  
6 we introduce them at this time, but I assumed that  
7 Mr. West was going to do what he just did, which is  
8 request that he cross-examine them. I just wanted to  
9 make sure he was still planning on doing that because  
10 we haven't talked about it in the last couple of days.

11 Given his statement, then, I guess  
12 what I'm requesting is that our record remain open  
13 for two weeks, during which time the parties will  
14 collaboratively schedule the depositions of these two  
15 individuals in Johnson City.

16 We will videotape that and transcribe it  
17 and submit it to the Court at the time the transcript  
18 is prepared and the videotape is ready, at which time  
19 the record will be closed. So that is what I'm  
20 proposing in lieu of his renewed request to  
21 cross-examine the individuals.

22 MR. GRANT: You mean in light of his --

23 MR. WEST: My standing request.

24 MR. JACKSON: Yeah. In light of the  
25 request you made earlier, which I just wanted to make

1 sure was still operative. That's all I was trying to  
2 do. I wasn't trying to complicate it.

3 THE COURT: And not to confuse this any  
4 more, I guess that puts you in a position where -- you  
5 don't want to be put in a position where Mr. West then  
6 says, "Well, actually, I don't want to video them,"  
7 and then you're left with no proof.

8 MR. JACKSON: Well, Your Honor, I  
9 guess if that happened -- if he lets me know in the  
10 next two weeks that he doesn't wish to conduct the  
11 cross-examination, I would then submit the affidavits  
12 to the Court, and I assume he would not object to that  
13 under those circumstances.

14 THE COURT: And that sounds fair.

15 MR. WEST: That's fair, Your Honor, yes,  
16 it is.

17 THE COURT: We'll do one of two things.  
18 The affidavits will be submitted -- well, either way  
19 they're going to be late-filed exhibits. So the  
20 affidavits will be submitted late, or you will submit  
21 deposition transcripts or video of the two affiants.

22 And what about time frame on that? I  
23 don't want to just -- and I know the -- leave a lot  
24 open. I know you have two doctors and they're in a  
25 different city and there's some scheduling concerns

1 all the way around.

2 MR. WEST: I don't mean to interrupt,  
3 Your Honor, but we're prepared, if it's necessary, to  
4 take their depositions in the evening, for example, or  
5 at their offices or wherever it's appropriate and, you  
6 know, to minimize the impact on the witnesses.

7 MR. JACKSON: I mean, I think, Your  
8 Honor, two weeks is reasonable, and the Court's -- we  
9 haven't set our deadlines yet for submission of the  
10 findings and conclusions, but I presume it will be --  
11 we'll get more than two weeks to do that, so I don't  
12 think that should impact us.

13 Don't you think we can do it within two  
14 weeks, Mr. Swearingen?

15 MR. SWEARINGEN: Yeah. Hopefully, we  
16 should be able to get that accomplished.

17 THE COURT: And I won't put a deadline  
18 where you're scrambling up there two weeks from now on  
19 a Friday afternoon, but just if you're cognizant of  
20 trying to get it done as quickly as possible. And I  
21 know you all probably want to do that too while these  
22 matters are fresh in your mind. And so that the  
23 record's clear, the two affiants are Dr. Karl Goodkin  
24 and Dr. Teresa Kidd.

25 MR. JACKSON: That's right, Your Honor.

1           Your Honor, the only other housekeeping  
2 matters before we rest our case, I had prepared -- we  
3 believe we've now prepared an Exhibit 9, which is the  
4 application which omits the letters of support, and  
5 I've just given a copy of that to Mr. West. And then  
6 we also went ahead and prepared a new Exhibit 80,  
7 which is Mr. Sullivan's report from which we redacted  
8 the letters that were excluded except for the letter  
9 of Dr. Elliott at Page 23, and I've just given  
10 Mr. West a copy of that also. So I would tender the  
11 substitute Exhibit 9 and substitute Exhibit 80 at this  
12 time.

13           MR. WEST: Your Honor, I just received  
14 the substitute Exhibit 80. It appears that the  
15 Number 9 is as Mr. Jackson has described, but I do  
16 want to review this with Mr. Sullivan and make sure  
17 that it's accurate in terms of what the redactions  
18 have been.

19           But I did want to ask Mr. Jackson: The  
20 redactions were limited to what pages?

21           MR. JACKSON: I believe -- and I  
22 apologize for just getting this to you. We just got  
23 it this morning ourselves. They go from Page 19  
24 through 22. I believe that's it.

25           MR. WEST: The lower half of 19, all of

1 20, all of 21 and all of 22?

2 MR. JACKSON: That's correct.

3 MR. WEST: All right.

4 THE COURT: The one that you agreed to,  
5 why don't we go ahead and substitute that out with the  
6 court reporter. We'll have to get a new sticker.

7 MR. JACKSON: Your Honor, at this time,  
8 Mountain States Health Alliance rests its cases.

9 THE COURT: And just to follow up, we're  
10 good on all the exhibits now.

11 Counsel, everything -- anything that  
12 needs to be redacted, added to? Those are the only  
13 two I remember, but...

14 MR. WEST: That's my recollection at this  
15 time, Your Honor.

16 MR. JACKSON: Your Honor, the only  
17 other potential wrinkle -- I need to go through the  
18 exhibits. There were some documents that were marked  
19 highly confidential in this proceeding and some have  
20 been introduced into evidence. And I need to take a  
21 moment at some point later today and go through those  
22 to see how sensitive the information is that's in the  
23 record, because if it is highly sensitive -- and I  
24 just need to confer with my client on that -- then I  
25 might ask that those particular exhibits be placed

1 under seal just so they're not available publicly  
2 should anyone request them, which  
3 I highly doubt will happen. But, you know, some of  
4 these things involving financial matters are  
5 sensitive. I'm not sure if anything we've actually  
6 introduced is that sensitive, so I just need to go  
7 through all of the exhibits for that.

8 So I would just ask the Court, if that's  
9 the case, if I can identify those here in the next day  
10 or two, I can contact the Court via email, if that's  
11 appropriate, copy Mr. West and request that those  
12 particular exhibits be placed under seal for  
13 confidentiality purposes.

14 And my only other request would be that  
15 the Court acknowledge -- or I'm asking that the Court  
16 find that the protective order is still in place in  
17 this case; insofar as highly confidential documents  
18 have been disclosed in the case, that they still be  
19 restricted in their dissemination to third parties  
20 or whatever. I'm sure we can all agree that those  
21 highly confidential documents should remain subject to  
22 the protective order. Those are my only two requests  
23 about the exhibits.

24 THE COURT: Well, you have an agreed  
25 protective order that --

1 MR. WEST: Yes, Your Honor, but --

2 THE COURT: -- that you've entered into  
3 and I signed, so I assume that speaks to both of the  
4 issues you've raised in some capacity.

5 MR. JACKSON: Yes, it does, Your Honor.

6 MR. WEST: Your Honor, if I may, I did  
7 want to ask -- if I may voir dire Mr. Jackson here  
8 for a second. There's been no question as far as  
9 Dr. Collier's report that all of it could be disclosed  
10 to, like -- such as Mr. Shaheen or Mr. Garone except  
11 for the last, I believe, three exhibits. And given  
12 the fact there's been so much testimony in public  
13 about it, I would ask whether they still considered  
14 those to be things that should not be available  
15 subject to the -- sort of be moved down to the  
16 confidential level as opposed to the highly  
17 confidential so that Mr. Shaheen can examine them,  
18 for example.

19 MR. JACKSON: I think, Your Honor, at  
20 this point, since he sat through the testimony and  
21 heard and saw the numbers, it would be kind of  
22 pointless to keep him from having a copy.

23 MR. WEST: Thank you, Mr. Jackson.

24 THE COURT: So Mountain States rests.

25 Mr. Christoffersen, I assume you have no

1 proof to present based on your earlier comments.

2 MR. CHRISTOFFERSEN: That's correct, Your  
3 Honor. The only wrinkle I would add, and perhaps this  
4 is just my lack of clarity, is I would ask whether or  
5 not the issue of admitting the transcript from before  
6 the Agency has been resolved or if that's still out  
7 there.

8 THE COURT: Well, as far as I'm  
9 concerned, there was never an issue to be resolved.  
10 I've heard people say "transcript," but no one has  
11 presented that to me.

12 MR. CHRISTOFFERSEN: Thank you.

13 THE COURT: So now rebuttal proof,  
14 Mr. West?

15 MR. WEST: Yes, we have some brief  
16 rebuttal utilizing Mr. Sullivan, our expert.

17 MR. JACKSON: Your Honor, may I ask the  
18 Court to inquire of the nature of the rebuttal? If  
19 Mr. Sullivan's simply going to come and comment on  
20 Dr. Collier's testimony, that's not proper rebuttal.  
21 He had a full disclosure of her opinions in advance of  
22 the trial and has had it for quite a few months, and  
23 anything that he had to say about her opinions he  
24 should have offered when he was called first. So I  
25 would submit that it's not proper rebuttal to allow

1 him -- if that's what he's going to do, and I don't  
2 know. So I would ask the Court, please, to inquire of  
3 counsel whether or not that is the nature of the  
4 proof, and if so, we would object.

5 THE COURT: Well, let's wait and see what  
6 it is and then you can object at that time. He has  
7 the right to present any rebuttal proof. And so maybe  
8 the best thing to do at this point, though, given the  
9 time and when we started, is just to take a short  
10 break and come back and we'll do that.

11 MR. JACKSON: Thank you, Your Honor.

12 (Recess observed.)

13 THE COURT: All right. Mr. West, you  
14 indicated you wanted to call a rebuttal witness.

15 MR. WEST: We would like to call Dan  
16 Sullivan, our expert, to the stand.

17 THE COURT: Mr. Sullivan, you're still  
18 under oath.

19 MR. SULLIVAN: Yes, sir.

20 DANIEL J. SULLIVAN

21 was called as a witness, and having been previously  
22 sworn, was examined and testified as follows:

23 DIRECT EXAMINATION

24 BY MR. WEST:

25 Q. Mr. Sullivan, you have been here throughout

1 the hearing, correct?

2 A. Yes.

3 Q. You were here for Dr. Trivedi's testimony?

4 A. I was.

5 Q. You will recall that Dr. Trivedi set forth in  
6 his testimony that mental health services should be  
7 provided in the least restrictive setting?

8 A. Yes.

9 Q. Is there anything in the SBH proposal before  
10 the Court here today that is inconsistent with  
11 treating patients in the least restrictive setting?

12 A. In my view, no.

13 MR. JACKSON: Excuse me, Mr. Sullivan.  
14 Your Honor, please, this issue of least  
15 restrictive treatment was covered in Dr. Trivedi's  
16 report. As you'll recall, he presented that box  
17 that showed the range of treatment options from least  
18 restrictive to most restrictive and expressed opinions  
19 about that in his report which was disclosed several  
20 months ago which, presumably, Mr. Sullivan had access  
21 to before his original testimony, so we would object  
22 to this as being outside the scope of rebuttal.

23 MR. WEST: Your Honor, please, if I  
24 may respond. There was much more testimony by  
25 Dr. Trivedi, in my memory, about least restrictive

1 well beyond his report. He expanded it on out. And I  
2 think because he didn't just limit himself to talking  
3 about that box on the report or text in the report but  
4 testified more generally about it, then I have the  
5 right to ask rebuttal questions of Mr. Sullivan.

6 THE COURT: Okay. I don't have his  
7 report in front of me, that particular box. And,  
8 of course, he did just testify -- the box you're  
9 referring to in his report he did just testify to  
10 yesterday, but I can't say that I'm going to verbatim  
11 remember everything he said and whether or not it's  
12 all covered in the box.

13 To the extent Mr. West is accurate, that  
14 it went beyond that, and perhaps even if not so, they  
15 do get the opportunity, if they want to, to present  
16 evidence that explains or contradicts evidence that  
17 was put on by the other side, so I'll allow the  
18 question.

19 MR. JACKSON: Thank you, Your Honor.

20 BY MR. WEST:

21 Q. Will you proceed with your answer,  
22 Mr. Sullivan?

23 A. Sure. I won't try to restate entirely  
24 Dr. Trivedi's testimony, but he talked about the  
25 desire to keep folks out of the hospital, particularly

1 children out of the hospital, and I believe that  
2 that's consistent with what SBH has proposed. They're  
3 proposing multiple levels of care that they would  
4 provide.

5 There was also testimony at this hearing, as  
6 well as in the application -- there was discussion of  
7 their commitment to work with the community resources,  
8 like Frontier and other community agencies, in  
9 channeling patients to the appropriate level of care.

10 So, you know, the point I think that  
11 Dr. Trivedi didn't cover is that there are some  
12 patients who require inpatient treatment, and having  
13 those inpatient services available and accessible are  
14 an important part of having a well-coordinated mental  
15 health system.

16 Q. In his testimony yesterday or whenever, in  
17 your view, were there any important considerations  
18 regarding health planning that he did not address?

19 A. Yes. You know, he had a very interesting  
20 discussion about his views on health care policy as it  
21 relates to the delivery of mental health services, but  
22 he never really addressed the fact that in Tennessee  
23 there is a State Health Plan. There are guidelines  
24 that lay out the situation in which inpatient beds  
25 should be allowed in a community. And Dr. Trivedi

1 really didn't talk about that at all.

2           What he talked about was alternatives to  
3 inpatient care without really getting into the issue  
4 of when would it be appropriate to add inpatient beds,  
5 and I think the Guidelines for Growth set out what  
6 those conditions are.

7 Q.       Mr. Sullivan, Dr. Trivedi, as well as other  
8 witnesses, had discussed the proposed adolescent CSU  
9 that's under discussion in -- to be established in  
10 Gray, Tennessee, in Washington County. What is your  
11 view of whether this CSU is an alternative to the  
12 services, any of the services proposed by  
13 SBH-Kingsport?

14 A.       In my view, it's not what I would consider to  
15 be a viable alternative for a few reasons. First of  
16 all, it doesn't exist. It's merely in the planning  
17 stages. It's not clear when or if it will be finally  
18 developed. I mean, there's no construction underway.  
19 There's no final agreements. And so I think it falls  
20 into the category of speculation right now.

21           And then secondly, there's really no way to  
22 know what the impact of that CSU will be on the need  
23 for additional inpatient services. So we're really  
24 dealing with sort of a double level of speculation as  
25 it relates to the CSU. So I think that in evaluating

1 alternatives that are out there, you have to look  
2 at things that exist in the community now and not  
3 something that's speculative and may or may not happen  
4 in the way that it's been described.

5 Q. Were you here for Dr. Collier's testimony?

6 A. I was.

7 Q. And did you hear her testify concerning her  
8 belief that the goal of health planning -- she does  
9 not believe that the goal of health planning is to  
10 increase use of services?

11 A. Yes.

12 Q. Do you agree with that testimony?

13 MR. JACKSON: Your Honor, I object. I  
14 think she said inpatient services. But, in any event,  
15 I object to counsel characterizing her testimony  
16 imprecisely. If he wants to refer to specific  
17 testimony of Dr. Collier as recorded by the court  
18 reporter, that's one thing, but I think his  
19 characterization is inaccurate and I would object.

20 MR. WEST: Your Honor, I believe that  
21 this is an appropriate question for Mr. Sullivan.  
22 Dr. Collier did, in my recollection, testify  
23 concerning use of services and its interaction with  
24 health planning purposes, and that's the question I'm  
25 raising to Mr. Sullivan. I'll accept that it should

1 be limited -- my question should be limited to  
2 inpatient services, but...

3 THE COURT: Why don't you rephrase it  
4 with that.

5 MR. WEST: Okay.

6 BY MR. WEST:

7 Q. So you were here for Dr. Collier's testimony?

8 A. I was.

9 Q. And do you agree with any statements she may  
10 have made that she does not believe that the goal of  
11 health planning is to increase use rates of inpatient  
12 services?

13 A. I would agree with that in part. You know,  
14 health planning isn't purely about increasing use of  
15 services, but it is about increasing use of services  
16 when services haven't been fully accessible to a  
17 particular population.

18 Oftentimes in these CON matters, levels of  
19 utilization by the population are used as an important  
20 consideration in determining whether there's a need  
21 for additional services and so -- and I won't repeat  
22 my testimony about utilization rates in the service  
23 area that I mentioned before.

24 Q. Dr. Collier testified about the number of  
25 beds in -- number of inpatient psychiatric hospital

1 beds in Tennessee and characterized it as a rate of  
2 32 beds per 100,000 people.

3 A. Yes.

4 Q. And because of that, there's -- do you agree  
5 that because of that there's no reason to be concerned  
6 about the use rates of inpatient psychiatric hospital  
7 services in Northeast Tennessee?

8 A. I don't.

9 Q. Why not?

10 A. Well, the beds in Tennessee are not  
11 well-distributed. I mean, in health planning terms,  
12 they're maldistributed throughout the state. They're  
13 clustered around the larger cities like Memphis and  
14 Nashville. And so looking at the bed-to-population  
15 ratio on a statewide basis really doesn't tell you  
16 anything about what the appropriate level of  
17 utilization would be in an area like northeastern  
18 Tennessee.

19 And if you want to look at the  
20 bed-to-population metric in the service area that  
21 SBH has defined, there's only four beds per 100,000  
22 currently, so well below the 30 beds per 1,000 [sic],  
23 and well below the average of Tennessee of 32 beds per  
24 100,000.

25 Q. I want to move on to testimony from

1 Dr. Collier concerning a case that you were involved  
2 in in Livingston, that arose out of Livingston,  
3 Tennessee. Did you hear her testify about that?

4 A. I did.

5 Q. Do you agree with her characterization of your  
6 opinions in that case or your opinion in that case?

7 A. I do not.

8 Q. Why not?

9 A. I think that my opinions in that case are  
10 perfectly consistent with my opinions in this case.  
11 In that case it was a much different fact situation.  
12 That was an existing hospital that had historical  
13 patient origin.

14 And my testimony in that case was you should  
15 look at the actual historical patient origin in  
16 defining the service area for that particular  
17 applicant, which the applicant had not done; they had  
18 picked a different service area.

19 In this particular case, I looked at actual  
20 historical utilization data for other providers in  
21 Sullivan County in my assessment of whether the SBH  
22 service area was reasonable or not. And so I see  
23 the -- you know, in my view, I mean, those two things  
24 are consistent.

25 I think there was also some discussion about

1 whether or not I had considered providers outside  
2 the service area. In the Livingston case, they were  
3 proposing to provide geriatric psychiatric services,  
4 and they made a point in their application that those  
5 services weren't geographically accessible. I looked  
6 at where the existing geriatric psychiatric providers  
7 were.

8 In this case, there's only one provider  
9 that provides the same range of services that's being  
10 proposed by SBH, and that's Woodridge Hospital. My  
11 report goes into extensive discussion about Woodridge,  
12 its availability, its location and so forth. So,  
13 again, I don't see any inconsistencies.

14 Q. Dr. Collier testified at length about another  
15 one of your cases, the Baptist-Huntingdon project.

16 A. Yes.

17 Q. Did you hear that testimony?

18 A. I did.

19 Q. Do you agree with her testimony about the  
20 issues in that case and your involvement?

21 A. No. She -- I think she was specifically  
22 talking about the points that were raised in that  
23 Baptist-Huntingdon case regarding the impact on  
24 providers that were supported by state appropriations.  
25 And I think her comment was that in this case I said

1 that that standard was not applicable, but I think  
2 that's just factually incorrect.

3 If you look at my report, on Pages 14 and 15,  
4 there's actually a discussion of the potential impact  
5 on this project of the existing regional mental health  
6 institute for the region, which is now Moccasin Bend  
7 in Chattanooga.

8 And also there was a discussion about  
9 Woodridge and the fact that it received state  
10 grant money which I said is not exactly the same  
11 thing as appropriations, but I addressed the impact  
12 on Woodridge in a couple of different places in my  
13 report.

14 Q. Did you hear Dr. Collier's testimony in which  
15 she compared the service area of SBH's facility in  
16 Wilmington, North Carolina, with the service area  
17 proposed by SBH in this case?

18 A. Yes.

19 Q. What is your view as to whether that  
20 comparison is valid?

21 A. In my view, it's not a valid comparison. I  
22 mean, first of all, it's a different kind of facility.  
23 It's primarily a residential treatment facility with  
24 long-stay patients with a smaller acute care unit, and  
25 it's only for adolescents.

1           Secondly, she did no analysis about the  
2           availability of services similar to that in the  
3           southeastern North Carolina area surrounding  
4           Wilmington, and so, unlike the situation we have with  
5           SBH's proposal in Kingsport, there is a large existing  
6           comprehensive provider located in Washington County.

7           There's no evidence that there were any  
8           similar competing facilities around there and that its  
9           service area somehow expanded beyond where existing  
10          similar providers were located.

11                   MR. WEST: Thank you, Your Honor. That  
12          concludes my rebuttal questions for Mr. Sullivan.

13                                   CROSS-EXAMINATION

14          BY MR. JACKSON:

15          Q.           Good morning, Mr. Sullivan. You mentioned  
16          this state appropriations question, and that's the  
17          particular requirement in the Tennessee CON rules that  
18          says you have to determine the impact of the proposal  
19          on services supported by state appropriations, true?

20          A.           True.

21          Q.           And you said a minute ago that Dr. Collier  
22          misunderstood you, that you did consider that issue in  
23          this case, right?

24          A.           Yes.

25          Q.           But you'd agree, wouldn't you, that at

1 the bottom of Page 14 of your report, you say that  
2 "Woodridge is a facility supported primarily by  
3 revenues from Medicare and TennCare as well  
4 as private insurers and therefore would not be  
5 considered under this guideline"? That's what you  
6 wrote, right?

7 A. That's what I did write. I also discuss  
8 Moccasin Bend in that same section.

9 Q. I guess since you state it in your report that  
10 it shouldn't be considered in this guideline, you can  
11 understand, can't you, why Dr. Collier took you at  
12 your word on that?

13 A. No. She said I stated it was not applicable.

14 Q. Well, you said it shouldn't be considered.  
15 Isn't that the same thing as saying it's not  
16 applicable?

17 A. No. She made the blanket statement that  
18 it was not applicable to anybody. And I said in  
19 my report it was applicable to Moccasin Bend and I  
20 didn't believe there would be a significant impact  
21 on Moccasin Bend and I didn't think it was directly  
22 applicable to the Woodridge project, but I went on to  
23 discuss the impact on Woodridge otherwise.

24 Q. Isn't it true, Mr. Sullivan, that in your  
25 other case, you looked at it -- you interpreted that

1 guideline as being -- as referring to TennCare  
2 standing alone, right?

3 A. I said that was one aspect of it that could be  
4 considered under that.

5 Q. And in this report, though, you wrote the  
6 opposite. You wrote that Woodridge gets its money  
7 from Medicare and TennCare so you wouldn't consider it  
8 under this guideline, right?

9 A. I was talking specifically about state  
10 appropriations, but I went ahead and talked about the  
11 impact on Woodridge.

12 Q. On this Livingston case -- strike that.  
13 Wilmington, North Carolina, you don't know for  
14 sure what other providers there are in that area,  
15 right?

16 A. I know generally because I've done work in  
17 North Carolina. I'm not aware of any other similar  
18 providers located in close proximity to Wilmington.

19 Q. Well, what do you consider close proximity?  
20 Where is the nearest provider?

21 A. Raleigh, as far as I know.

22 Q. Do you know how far away that is?

23 A. It's about 180 miles.

24 Q. You agree, though, don't you, that the service  
25 area for child and adolescent services is broader than

1 regular psychiatric services, right?

2 A. I would agree with that, because there are few  
3 facilities.

4 Q. And the service area for psychiatric services  
5 of any type is broader than the services for acute  
6 care of any type, true?

7 A. Again, not always. It depends on the service.

8 Q. As a general rule, that's true, though, isn't  
9 it?

10 A. Generally, it would be comparable to what I  
11 would consider to be -- a full-service medical center  
12 would be comparable to what a psychiatric hospital  
13 service area would look like.

14 Q. You certainly don't agree with any suggestions  
15 that have been made in this case, for example, that  
16 the Johnson City Medical Center service area is small,  
17 right?

18 A. I don't believe it's small.

19 Q. It goes many, many counties around, correct?

20 A. Yeah. I mean, its primary service area, I  
21 think, encompasses five or six counties, and then its  
22 secondary service area would encompass a significant  
23 number of other counties.

24 Q. So these community needs assessments where  
25 they've divided up their region for administrative

1 purposes, you would agree those administrative regions  
2 don't correspond to the service areas that you would  
3 employ as a health planner, true?

4 A. Well, I think there's two different parts to  
5 that report, and I think the --

6 Q. Let me get an answer to my question first,  
7 Mr. Sullivan, and then if you feel the need to  
8 explain, you can.

9 You would agree that those administrative  
10 areas that are set out in the community needs health  
11 assessment do not represent service areas as you would  
12 define them as a health planner; isn't that correct,  
13 sir?

14 A. I would agree with the administrative part,  
15 but there are two different definitions in that  
16 report. One describes generally these administrative  
17 areas, and then there's a very specific discussion  
18 about the service area for the individual institutions  
19 in each report.

20 Q. But the service areas are where the patients  
21 come from, right?

22 A. That's right.

23 Q. They're not where the marketing is done for  
24 purposes of a community needs assessment, correct?

25 A. Right. I mean, I would not use the

1 information that was on -- I forget -- Page 4 of that  
2 report that breaks it up into four regions, but I  
3 would look at the service area that's defined in that  
4 report for each of the facilities.

5 Q. With respect to what's going to be done at the  
6 proposed hospital in Kingsport and how they're not  
7 just focusing on inpatient volumes -- you said that a  
8 few minutes ago, right?

9 A. I did.

10 Q. -- you've never seen any document of any kind  
11 explaining exactly what outpatient services they  
12 intend to offer, true?

13 A. I've not seen a document.

14 Q. You've not seen any projections of inpatient  
15 volumes, have you?

16 A. Inpatient or outpatient?

17 Q. I'm sorry. Outpatient volumes.

18 A. I have not.

19 Q. And whatever it says -- it says something in  
20 the application about outpatient services, right?

21 A. I think it discusses partial hospitalization  
22 and outpatient services.

23 Q. It gives no other details about it, right?

24 A. It does not.

25 Q. It doesn't explain how many patients will be

1 seen in that venue, does it?

2 A. There's no projections.

3 Q. And the projections for financial success are  
4 based on the inpatient volumes, right?

5 A. I believe that they're --

6 Q. Largely?

7 A. Largely. But there's a component of  
8 outpatient included in the revenue.

9 Q. But you don't even know how they came up with  
10 that, right?

11 A. Other than what Mr. Shaheen testified to.

12 Q. With respect to the CSU, I mean, you've heard  
13 now from at least three witnesses in this case who are  
14 directly involved in the process of planning for the  
15 adolescent CSU. You sat out there and heard that,  
16 right?

17 A. I did.

18 Q. And you obviously don't doubt that they were  
19 all telling the truth when they testified, right?

20 A. I think they're telling the truth that they're  
21 in discussions about developing one.

22 Q. Well, it's a little more than discussions.  
23 You heard them say they have a location, right?

24 A. Right.

25 Q. You heard them say they're working on the

1 protocols, right?

2 A. I did.

3 Q. You heard them say they're working on the  
4 letter of intent, right?

5 A. Yes.

6 Q. So you don't have any basis to opine that  
7 that's not going to happen? That's fair, isn't it?

8 A. I think it's fair to say we don't know whether  
9 it's going to happen or not because it hasn't happened  
10 yet.

11 Q. Well, you know, don't you, that these projects  
12 take a little time to do some planning, right?

13 A. Sure. And when it's up and running, then it  
14 would be an appropriate alternative to consider.

15 Q. All of your opinions about CSUs -- you've  
16 never worked in one, right?

17 A. Never have.

18 Q. You've never planned one yourself, have you?

19 A. I have not.

20 Q. You said that the state formula, if you  
21 applied it to the alternative service area, there are  
22 only 4 beds per 100,000 right?

23 A. Right.

24 Q. But that's applying it to that three-county  
25 area in Tennessee; is that right?

1 A. Two counties in Tennessee and three in  
2 Virginia.

3 Q. I'm sorry. Two in Tennessee and three in  
4 Virginia.

5 And, I mean, you would agree -- for example,  
6 if you took Hawkins County and just applied it to  
7 that, it would be zero per 100,000, right?

8 A. It would.

9 Q. But that doesn't mean that the health planning  
10 standard would be to go in and add 34 beds per 100,000  
11 to Hawkins County, right?

12 A. Sure. I mean, you have to develop a service  
13 area that's reasonable. I mean, if you were applying  
14 for a psych unit in Hawkins County, you would start  
15 with the 30 beds per 1,000 [sic], but I think then you  
16 would have to also show the broader area that you  
17 would draw the patients from.

18 Q. Right. It all comes down to the reasonable  
19 service area, doesn't it?

20 A. Absolutely.

21 Q. Thank you.

22 MR. JACKSON: One minute, Your Honor.

23 (Pause.)

24 BY MR. JACKSON:

25 Q. Also, you remember during your testimony

1 when you expressed the hypothesis that Woodridge was  
2 an ailing institution at the time and it had low  
3 admissions when it was competing with Indian Path  
4 Medical Center Pavilion? Do you remember advancing  
5 that theory?

6 A. There was an alien?

7 Q. Ailing, A-I-L-I-N-G. Sorry.

8 A. Yes, that's what --

9 Q. You remember you had that one page you found  
10 somewhere in the documents and you said this was --

11 A. Based on the data that I looked at, yes.

12 Q. You've heard now -- you know from the  
13 testimony we've had that you were off base on that a  
14 bit, right?

15 A. The volume was higher. I think it was still  
16 an ailing institution.

17 Q. But your hypothesis was generated from a  
18 volume number that you now know was incorrect; am I  
19 right?

20 A. Well, that wasn't the sole basis of my  
21 opinion, but, yes, the volume number was incorrect.

22 Q. Well, you also referenced in your opinion some  
23 deposition testimony, but you didn't say who it was.  
24 Who was it, exactly, that you think testified to that  
25 in this case?

1 A. I'm not sure exactly which point you're asking  
2 me about.

3 Q. I'm talking about when you advanced this  
4 hypothesis that the reason Indian Path Psychiatric  
5 Pavilion was seeing people from Washington County was  
6 that Washington County -- Woodridge was ailing in some  
7 way. There was that one document. We've agreed  
8 that's not a reliable document, right?

9 A. Yes.

10 Q. And then you said --

11 A. Well, not that it's not a reliable document.  
12 You have to adjust the one year number.

13 Q. That one year's numbers are off, right?

14 A. Okay.

15 Q. And then you said that there was some  
16 deposition testimony that suggested the same thing,  
17 and I'm just asking you who was it that said that.

18 A. My recollection is it was Ms. Bailey who  
19 talked -- because she had been there before the  
20 Mountain States takeover of the facility, and I think  
21 she talked about the fact that they were having some  
22 difficulties prior to the time that Mountain States  
23 stepped in.

24 Q. You would agree that when she came  
25 here and testified under oath and was subject to

1 cross-examination by Mr. West, she didn't say that,  
2 right?

3 A. I don't remember that question being asked.

4 Q. Okay. And Mr. West didn't confront her with  
5 this deposition testimony that you seem to be  
6 remembering, right?

7 A. Not that I recall.

8 Q. And Dr. Jessee, who works for the company that  
9 used to own it, he came and testified and said it was  
10 sold because of some rule changes, not because they --  
11 and that they were running a healthy census. You  
12 heard him say that, right?

13 A. I did. He said they were running, I think  
14 he said, 60 to 65 patients, but I think he said that  
15 financially they could no longer support the facility  
16 because of changes in the way the reimbursement would  
17 be administered.

18 Q. Right. Of course, that's not a problem with  
19 the facility, that's a problem with the change in the  
20 reimbursement rules, right?

21 A. Yeah. And when I was saying ailing, I'm not  
22 talking about the physical structure, I'm talking  
23 about the operations.

24 Q. Well, it was running 65 patients at the time  
25 and only had 71 beds, right?

1 A. 75.

2 Q. 75 beds. That's a pretty health occupancy,  
3 right?

4 A. Yeah. I mean, that doesn't mean that it's  
5 financially stable.

6 Q. Have you gone back and looked at the financial  
7 records of that hospital so that you could come here  
8 and opine that it was financially unstable?

9 A. No. I mean, Dr. Jessee's testimony was that  
10 they could no longer sustain it with the changes in  
11 the reimbursements.

12 Q. Well, that's because the way the checks -- the  
13 state changed the rules on them, right? That's not  
14 because the hospital wasn't -- didn't have patient  
15 volumes, right? Those are two different issues,  
16 right?

17 A. Yeah. And maybe we're kind of two ships  
18 passing in the night here. I mean, that's not really  
19 what I'm talking about, the patient volume.

20 Q. Well, I thought that you -- the whole reason  
21 that we got off on this tangent about the financial  
22 performance of Woodridge back in 2005 was because you  
23 declined to look at the patient origin data of  
24 patients going to Indian Path Psychiatric Pavilion  
25 during that time period because you said it wasn't an

1 even playing field. Do you remember that?

2 A. Sure.

3 Q. And, in fact, what we now know is that that  
4 hospital was healthy and competitive during that time  
5 period, right?

6 A. Well, we know that it had a high census. I  
7 don't know how competitive it was, because Mountain  
8 States owned Indian Path, and the patient origin  
9 patterns appear to show that Mountain States was  
10 referring patients from Washington County to Indian  
11 Path.

12 Q. Well, what the patient patterns show, sir, is  
13 that patients were going from Washington County to  
14 Indian Path Psychiatric Pavilion for treatment; isn't  
15 that true?

16 A. That's what it shows.

17 Q. And even though they had a hospital right  
18 there in Johnson City that was functioning at 70 and  
19 80 percent capacity, the hospital up in Kingsport was  
20 still able to attract more than -- approximately 12  
21 percent of the patients from Washington County, true?

22 A. That is correct, but it doesn't change the  
23 basic point I made about the competitive landscape  
24 changing. Because in those days, prior to 2006,  
25 Woodridge was not owned by Mountain States, and so the

1 patient flow patterns aren't necessarily indicative as  
2 they began to transition to focusing their services at  
3 Woodridge, and that's the situation we have today.

4 Q. And all of what you just said is just your  
5 speculation, isn't it?

6 A. Well, it's based on my observations.

7 Q. Okay. And it was based on that one piece of  
8 paper that we now know was not even accurate, true?

9 A. And also the current patient origin data for  
10 Woodridge.

11 MR. JACKSON: That's all I have.

12 MR. WEST: Your Honor, I have one brief  
13 question addressing a question Mr. Jackson raised with  
14 Mr. Sullivan. Well, actually it's two questions, but  
15 it's all limited to the same area.

16 REDIRECT EXAMINATION

17 BY MR. WEST:

18 Q. Mr. Sullivan, you're familiar with the  
19 projected data chart on the CON form?

20 A. Yes.

21 MR. WEST: And may I ask that the witness  
22 be shown -- I believe it's the new Exhibit 8, the CON  
23 application.

24 MR. JACKSON: It's Exhibit 9. What page?  
25 I'm sorry.

1 MR. WEST: It's the projected data chart  
2 for the CON application. I lost my place here. It's  
3 Page 49.

4 THE WITNESS: Bates 49?

5 BY MR. WEST:

6 Q. Yeah, Bates 49. Do you have it?

7 A. Yes.

8 Q. And this is the projected data chart of the  
9 CON application that's been filed in this matter?

10 A. Yes.

11 Q. What does it indicate about outpatient  
12 services gross revenue?

13 A. It shows that at 426,000 in the first year and  
14 1,040,000 in the second year.

15 MR. WEST: Thank you.

16 THE COURT: You can step down.

17 THE WITNESS: Thank you very much.

18 (Witness was excused.)

19 THE COURT: Do you have any further  
20 proof, Mr. West?

21 MR. WEST: No, Your Honor. That  
22 concludes our rebuttal.

23 THE COURT: All right. Counsel, we're at  
24 closing arguments, I believe. What do you-all propose  
25 about that?

1 MR. JACKSON: I'm ready to go, Your  
2 Honor, if Mr. West is.

3 MR. WEST: Your Honor, if I could have  
4 just a very short break to kind of get my papers in  
5 order and then we'll proceed ahead.

6 THE COURT: That's fine. Take a short  
7 break.

8 (Recess observed.)

9 MR. WEST: Bill West, again, on behalf  
10 of the applicant. I haven't done an oral argument in  
11 a contested case proceeding in a while, and I want to  
12 retain, if I may, a little bit of my time to respond,  
13 since we have the burden of proof -- to respond, if I  
14 need to, after Mr. Jackson speaks.

15 THE COURT: I think that will be fine.

16 MR. WEST: Your Honor, I know it's been a  
17 long hearing for all of us, and it's apparently going  
18 to be a pretty substantial record. But after all is  
19 said and done in this case, I believe SBH-Kingsport,  
20 LLC, has met its burden of proof and established that  
21 the project that they propose for the 72-bed  
22 psychiatric hospital to be located in Kingsport  
23 in Sullivan County is necessary to provide needed  
24 health care in the area to be served, and that's the  
25 statutory language from TCA 68-11-1609(b) in the CON

1 statute as outlined in my pretrial brief. I believe  
2 we've attached copies, but we certainly set it forth.

3 We also believe there's really not any  
4 question that the project meets the second criteria  
5 of whether it can be economically accomplished and  
6 maintained. There's certainly no question on the  
7 economic accomplishment given Mr. Shaheen's testimony  
8 in the record of this company in being able to develop  
9 these projects.

10 And the maintenance of it is, I think,  
11 supported by the fact that in its service area, those  
12 five counties, there are only 12 other psychiatric  
13 hospital beds, plus I believe Mr. Shaheen and  
14 Mr. Cagle testified at length -- not so much from  
15 Mr. Cagle at length, but this is a successful company.  
16 It's not nearly as big as Mountain States, but it has  
17 significant financial resources to maintain its  
18 hospital economically.

19 And then I believe it also can meet the  
20 third criterion, which is "Contribute to the orderly  
21 development of adequate and effective health care  
22 facilities or services." And I'll detail how that's  
23 done in a moment. But when you look at the, sort of,  
24 global set of circumstances here that have been  
25 described to this Court, there are no inpatient

1 facilities for psychiatric services in those five  
2 counties that we claim other than a 12-bed unit at  
3 this -- on the, sort of, eastern side of Sullivan  
4 County in Bristol.

5 And so you have an area where there  
6 used to be a provider, there's not a provider now,  
7 in Kingsport, of these services, and you have an  
8 applicant that's a successful applicant, successful in  
9 developing these projects. It is a private company,  
10 there's no question, but I believe the CON statute  
11 also provides that -- I need to look up the cite  
12 on this one, but basically that all applicants or  
13 people who -- and I think the board does this --  
14 all applicants who come before the board -- it's  
15 68-11-1603 is the policy provisions of the statute.  
16 And it says -- the final provision states that to the  
17 end of -- meaning the statutory goals -- this section  
18 of the code, the Health Planning Resources Development  
19 Act, shall be equitably applied to all health care  
20 entities, regardless of ownership or type, except  
21 those operated by the United States government.

22 So there's been discussion in the  
23 testimony in this case that SBH, because it's private,  
24 is somehow different as a provider from Mountain  
25 States. And I haven't looked at it in the economic

1 literature, but a highly leveraged nonprofit hospital  
2 may not be that much different in economic terms from  
3 a private company with shareholders or interest  
4 holders in an LLC. So that's another, sort of, part  
5 of the universe of facts in this case.

6 And even though it's not in our service  
7 area, there's been a tremendous amount of testimony  
8 about Woodridge down in Washington County and Johnson  
9 City. As Ms. Bailey testified, it's basically a  
10 department of Johnson City Medical Center, the  
11 flagship hospital of the Mountain States Health  
12 Alliance, and one that's financially very successful  
13 that I think we've shown through their joint annual  
14 reports that are in the record.

15 And I believe even today Mr. Levine  
16 talked about the range of services and the range  
17 of subsidies that Johnson City Medical Center, you  
18 know -- the services it provides and the subsidies it  
19 gets and the, sort of, quality of the flagship of -- I  
20 use that term as a compliment. It is a flagship, in  
21 my view, of Mountain States systems.

22 And Woodridge, by the testimony of the  
23 lady who basically operates it or who is on the  
24 ground, is a department of Johnson City Medical  
25 Center, the flagship of the Mountain States empire --

1 that's the wrong word -- set of hospitals.

2 And they're running -- it's not just that  
3 they're running at a high rate; they're running at a  
4 rate that's been steadily increasing. And the rate  
5 that's been established by the testimony in fiscal  
6 2015 is even higher than the high rate that was  
7 established in fiscal -- in 2006 is higher than the  
8 rate for the fiscal year just ended on June 30th.

9 And that is, I believe, when I get around  
10 to the impact or some of the broader areas that have  
11 been addressed -- that's something to keep in mind,  
12 because it is the only large provider of inpatient  
13 psych services in Upper East Tennessee. It is the  
14 only provider of inpatient child and adolescent  
15 facilities -- child and adolescent psych facilities  
16 in Upper East Tennessee or anywhere in the region,  
17 really.

18 And the CSU that's been talked about, as  
19 Mr. Sullivan says, it's not built yet and there's no  
20 indication of when it will be built, and to get built  
21 and be funded, they have to, among other things,  
22 change the rules of the mental health department about  
23 CSUs, if they intend to serve people under 18, because  
24 the rules are on the Secretary of State's website, and  
25 they currently provide that CSUs are not for patients

1 under 18. That won't be all that difficult a process,  
2 but it's one more indication that the system has to be  
3 altered for that to come to pass.

4 In any event, it's not in our service  
5 area. It's hard to tell just what the difference is  
6 between them based on the testimony. But we know one  
7 thing, a CSU is not an inpatient psych hospital. So  
8 it is qualitatively different from either Woodridge or  
9 what is proposed for SBH-Kingsport.

10 I'm going to next address the rules  
11 of the Agency which say that -- which address the  
12 three -- the three statutory criteria of need,  
13 economic feasibility -- economic factors they call  
14 it -- and contribution to the orderly development of  
15 adequate and effective health care facilities or  
16 services.

17 On the need side -- and these are cited  
18 in our pretrial brief, and we'll certainly address  
19 them in detail in our proposed conclusions of law --  
20 the Agency says the health care -- as to need, health  
21 care needed in the area to be served may be evaluated  
22 on the following factors.

23 I wanted to focus for a minute, if I  
24 may, Your Honor, on that language of "in the area  
25 to be served." That's a clause from the statute,

1 68-11-1609(b), that sets out the three criteria.

2 The area to be served and the service  
3 area, we submit, are the same thing. There are ways  
4 that the rules of the Agency have about talking about  
5 the service area. The service area is what the  
6 applicant defines as a service area. And I believe  
7 even Ms. Collier said the market share for the service  
8 area or the primary could be as low as 60 percent. So  
9 it's not 95 percent; it's not 90 percent. It's where  
10 the majority of the patients come from, essentially.

11 And we propose and we set forth  
12 justifications for, and I believe Mr. Sullivan has  
13 articulated, that our service area is appropriate.  
14 By "our," I mean SBH-Kingsport's service area is  
15 appropriate, but -- I will switch back to addressing  
16 these HSDA rule factors.

17 The first one is 1(a), "The relationship  
18 of the proposal to any existing applicable plans."  
19 Well, the State Health Plan, we have addressed  
20 that at length in this proceeding, and that  
21 starts out essentially, fundamentally, with the  
22 30-beds-per-100,000 population ratio that you've heard  
23 so much about. And certainly, looking at what's in  
24 our proposed service area in terms of the supply of  
25 beds and the population, our project complies with the

1 30-beds-per-100,000 population ratio requirement.

2 And then it says "The population to  
3 be served by the proposal." We've identified that  
4 as those five counties: Hawkins and Sullivan in  
5 Tennessee; Wise, Scott, and Lee in Virginia. Which,  
6 interestingly, Dr. Jessee said, as far as Frontier  
7 goes, they also claim Wise, Scott, and Lee in  
8 Southwest Virginia.

9 And on their website, the picture in  
10 their history is of a building in Kingsport, so it's  
11 logical that people in Kingsport, organizations in  
12 Kingsport would serve the three-county Southwest  
13 Virginia area of Wise, Scott, and Lee.

14 And then the next provision of the rule,  
15 the existing or certified services or institutions in  
16 the area, again, we go back to: What is the area  
17 provided? Well, it's those 12 beds in Bristol.  
18 That's the only 12 beds in the whole five-county  
19 area. So the need is there even if you take into  
20 consideration of those 12 beds.

21 Next issue is special need of the  
22 service area population, including, among other  
23 things, TennCare participants and low-income groups.  
24 As SBH has indicated in its application and its other  
25 hospitals, TennCare is a Medicaid program, and SBH is

1 a high-volume Medicaid provider in other places and  
2 will provide a significant volume of Medicaid services  
3 here.

4 Now, we understand that we're what's  
5 called an IMD, an institute of mental disease, but  
6 we will provide services to children and adolescents,  
7 and those are eligible Medicaid populations. So, from  
8 that standpoint, we -- and I believe Mr. Shaheen  
9 testified about discussions with the Medicaid  
10 authorities about possible state contract levels  
11 Medicaid paid for TennCare patients.

12 And then the next provision says,  
13 "Comparison of utilization and occupancy trends  
14 and services provided by other area providers."  
15 Mr. Sullivan has addressed that. There's only one in  
16 our area, and that's over in Bristol. He addressed  
17 that at length in his report.

18 Then the final one under this Agency  
19 rule is the extent to which Medicare, Medicaid,  
20 TennCare, medically indigent and charity care  
21 patients, low-income patients will be served.  
22 Clearly, we plan to provide Medicare for the  
23 geropsychiatric patients and Medicaid for the children  
24 and adolescents. And I think also, possibly, some  
25 other eligibility may be in there, but we certainly

1 are going to serve the children and adolescents.

2 And it says how the applicant has  
3 assessed providers of services which will operate in  
4 conjunction with this. I think Mr. Shaheen testified  
5 they met with Frontier. I believe Mr. Jessee said  
6 they met with somebody from Strategic, as I recall his  
7 testimony.

8 The letters of support and the tracker  
9 document that Mr. Garone testified about shows that  
10 they have been out in the community, consulted with  
11 them, and therefore we believe we've met that factor.

12 The economic factors -- again, I  
13 don't think there's any question of whether adequate  
14 funds are available to SBH-Kingsport to complete  
15 the project. This is on Subsection 2 of the Agency  
16 rules. "The reasonableness of the project costs."  
17 Mr. Shaheen has been criticized -- or his company has  
18 been criticized for taking a, quote, off-the-shelf  
19 plan. One of the things that does, I believe he  
20 testified, is it drives the project costs down. And  
21 so I don't think there's any -- I've heard no  
22 criticism about the project costs by anyone.

23 And the next factor under Economic  
24 Factors in the Agency rules is "Anticipated revenues  
25 and the impact on existing patient charges." Well,

1 they don't have any existing patient charges, and  
2 they've described in detail the anticipated revenue.

3           Participation in state and federal  
4 revenue programs is the next one. We're obviously --  
5 SBH-Kingsport will participate in Medicare and  
6 Medicaid or TennCare.

7           The alternatives considered,  
8 Mr. Shaheen and Mr. Garone had discussions, I believe,  
9 if I recall the testimony at this hearing -- they  
10 actually met with Mountain States personnel and  
11 obviously with Frontier.

12           And the final factor under this rule is  
13 the availability of less costly or more effective  
14 methods of providing benefits intended by the  
15 proposal. If the testimony about the adolescent --  
16 or the CSUs, in general, is considered, I think  
17 Dr. Trivedi made it clear, hospital companies can't  
18 run CSUs. He said it wasn't a rule, but there's a  
19 policy at the state Department of Mental Health that  
20 they essentially don't want that to happen. They've  
21 turned this task over to the community mental health  
22 centers. So having a CSU is not an alternative that  
23 SBH-Kingsport could have pursued.

24           And the one thing about inpatient  
25 psychiatric hospitals is they are a level of service

1 that, in our belief, and I think in the facts and the  
2 expert testimony -- there's been a lot of criticism  
3 about where they fall in the system, but there has to  
4 be some inpatient hospital capacity because they do  
5 things that no other provider, like a CSU or a  
6 community mental health center, can provide. They  
7 provide the highest level of care. They provide a  
8 range of care, including the highest level of care.

9           The final rule/factor in the Agency  
10 rules is the "Contribution of orderly development  
11 of adequate and effective health care facilities or  
12 services." And I think this focuses, in this case,  
13 on services. And when you look at -- the first factor  
14 under that rule is the relationship of the proposal  
15 to the existing health care system. That includes  
16 TennCare participation, which, of course, we will do.

17           "Affiliation of the project with  
18 professional skills," and this, I think, is an  
19 important point that Dr. Elliott's testimony made way  
20 back at the beginning of the hearing, that ETSU's  
21 medical school needs to have access to child and  
22 adolescent board-certified psychiatrists to be  
23 adequately accredited, and I believe he testified  
24 about that. And he certainly testified that he  
25 supported our project. And he was the residency

1 program director, which is how hospitals affiliate  
2 with medical schools.

3 And as you heard Mr. Levine testify  
4 today, Johnson City Medical Center has a number of  
5 residency -- or Mountain States has a number of  
6 residency programs that typically feature Johnson  
7 City Medical Center, and that's a good thing. Because  
8 ETSU has a medical school, it needs places for its  
9 residents to be trained, and you have to have a  
10 board-certified child and adolescent psychiatrist to  
11 have a complete residency program for psychiatry  
12 residents, which I believe Dr. Elliott testified to.

13 And Mr. Shaheen testified at some length  
14 that his company already has access to them and will  
15 provide one at the SBH-Kingsport project, so -- and  
16 also is willing, and does elsewhere, to affiliate with  
17 health professional schools such as medical schools.  
18 I believe the example that he used was in Texas,  
19 but clearly, Dr. Elliott had been excited about  
20 SBH-Kingsport developing a hospital in Kingsport, a  
21 psychiatric hospital in Kingsport. His letter says  
22 that, and I think his testimony -- his willingness to  
23 come here on his move to Michigan to testify in this  
24 proceeding I think speaks volumes about how he feels  
25 about this project.

1                   And this is a gentleman who, three or  
2 four weeks ago, was seeing patients at Woodridge and  
3 at his ETSU medical school clinic program. So this  
4 is a psychiatrist in the area -- or in Washington  
5 County, where the medical school is, and he said that  
6 he believed the project was needed and that it would  
7 help the medical school.

8                   So we've heard a lot of different  
9 testimony here. And I respect Dr. Trivedi, and he's  
10 certainly an accomplished physician, but Dr. Elliott's  
11 testimony is from somebody who was in the trenches,  
12 and he talked about how hard it was for him to find  
13 care for his patients when he left his practice there  
14 in mid-June of this year.

15                   And then we get to the positive or  
16 negative effects attributed to duplication or  
17 competition. And the interesting thing about this  
18 provision is that a lot of people focus on the  
19 negative effects of competition, but it also says the  
20 positive effects of competition.

21                   And one of the things I wanted to address  
22 in my closing, which is turning out to be longer than  
23 I thought, is that SBH-Kingsport filed this CON  
24 application in December of 2013. And it's interesting  
25 and, I think, suggestive, at least, as to what has

1 happened since then.

2           The next month, January 2014, utilization  
3 at Woodridge in Johnson City starts to rise  
4 dramatically. It may be attributable to the changes  
5 they made, but it may also be attributable to the  
6 sense that there might be competition. And then about  
7 the same time, according to Dr. Jessee's testimony,  
8 discussions began to emerge about the establishment  
9 of an adolescent CSU. Is it a coincidence? It's  
10 suggestive -- it's not direct testimony.

11           But all of those things began when  
12 SBH-Kingsport published in the paper up in East  
13 Tennessee that they wanted to establish a 72-bed  
14 inpatient psychiatric hospital in Kingsport. So just  
15 the mere hint or threat of competition has led to more  
16 services being provided in Woodridge. It's led to  
17 these discussions, however they may eventuate, about  
18 an adolescent CSU being developed in Washington  
19 County.

20           So that's a positive effect of just  
21 the threat of competition or just the hint of  
22 competition. We believe that there's positive effects  
23 to competition in that, as Dr. Elliott indicated,  
24 there's no child and adolescent board-certified  
25 psychiatrist up in that area that they can send their

1 residents to train under. SBH-Kingsport would supply  
2 that. That's competitive in the sense that it's  
3 providing new services to the medical school of ETSU.  
4 So, once again, competition doesn't -- competition has  
5 positive effects as well as negative effects.

6 Are there negative effects? Well,  
7 there's been a lot of testimony about the financial  
8 impact, but I think the other thing that goes unsaid  
9 in that analysis generally is that the utilization  
10 rates or use rates of the population for psychiatric  
11 services seem less in the rural counties like Hawkins  
12 and the three Virginia counties than they are in  
13 Washington County. If those rise, more services are  
14 being delivered, not just inpatient services, but  
15 Mr. Shaheen said they would provide outpatient  
16 psychiatric or mental health services as well. So,  
17 in sum, we think -- we agree with what Mr. Sullivan  
18 said: In sum, this is a desirable project from  
19 standpoint. And we agree with that statement.

20 Next, the availability of human resources  
21 required by the proposals, including consumers and  
22 related providers, I think Mr. Shaheen has made it  
23 clear they can provide the related providers, bring  
24 them into an area -- I don't think anyone questions  
25 there's a need for child psychiatrists in East

1 Tennessee. SBH-Kingsport can help to meet that, other  
2 staff as well.

3 And I do believe, also, Mr. Shaheen  
4 indicated that the other staffing is readily  
5 available. That's why they chose Sullivan County --  
6 or Upper East Tennessee, depending on which place  
7 along the continuum of time you wish to look.

8 The quality of the proposed project,  
9 relation to applicable standards is the final one.  
10 It's on Page 5 of my memorandum. I don't think  
11 there's been any criticism of the quality of SBH's  
12 hospitals, generally, and I think Mr. Shaheen has  
13 indicated how they meet the quality standards and  
14 certainly they do in their other states. There's no  
15 reason to think that they won't here.

16 The State Health Plan, or what's called  
17 the Guidelines for Growth in the old term, also  
18 provides some criteria to address, and this starts  
19 on Page 5. This is the one that goes into detail  
20 about the 30 beds per 100,000 population, and that's  
21 what we've addressed at length in this case in our  
22 CON application.

23 In our five counties, we meet this  
24 standard, our bed count meets this standard. And then  
25 for adult programs, I think even Dr. Collier said we

1 met this standard for adults. For children under 13  
2 and adolescents, it is true that we have asked for  
3 more beds than the population formula for our five  
4 counties would generate.

5 But one of the things I believe -- I  
6 think Mr. Shaheen addressed this. Upper East  
7 Tennessee and Southwest Virginia have only 12 child  
8 and adolescent psychiatric beds total at this time.  
9 And so there's extra need, we believe, in the larger  
10 area, or certainly in our service area, for these  
11 beds, and so there is a larger component called for by  
12 our CON application.

13 And then the final component of the  
14 Guidelines for Growth is these estimates for need  
15 should be adjusted by the existing staff beds  
16 operating in the area. Again, "in the area" is the  
17 area to be served, which we believe is our service  
18 area of five counties. There are only 12. And so  
19 we'd certainly -- even after deducting those 12,  
20 there's a need.

21 The "Service area itself" provision  
22 is next. The geographic service area should be  
23 reasonable and based on an optimal balance between  
24 density of population and service proximity. I  
25 believe Mr. Sullivan addressed this in detail. The

1 providers in Kingsport -- the existing providers in  
2 Kingsport such as Holston Valley Medical Center,  
3 Indian Path Medical Center, HealthSouth's rehab  
4 hospital, they have service areas similar to ours.

5           And Indian Path Medical Center's service  
6 area -- I think we have from Mountain States itself  
7 the most recent iteration of what Indian Path Medical  
8 Center is, and it's the western half of Sullivan  
9 County, Hawkins County, and then it goes up into  
10 Virginia, along the lines of our service area.

11           And so the active two-hundred -- I  
12 believe it's 241-bed, somewhere in that range, acute  
13 care hospital operated by the intervenor in our -- the  
14 town we propose to locate in claims a service area  
15 very similar to ours. And it's not just a little  
16 hospital. It's one of their larger hospitals in the  
17 Mountain States Health Alliance program -- or company.

18           And then the service proximity,  
19 there's only 12 -- again, I keep going back. I keep  
20 reiterating some of these things, but I wanted to -- I  
21 have to address each of these factors, and so 12 beds  
22 in our claimed service area.

23           And then the relationship of the  
24 service area, Number 2 factor, is "The relationship of  
25 the socio-demographics in projected population to

1 receive services." And then, in this case, it says  
2 the sensitivity to special needs, accessibility to  
3 the consumers, the racial, ethnic and minority --  
4 I'm skipping some of them just to -- and low-income  
5 groups, and critically, for psych beds, those needing  
6 the services involuntarily. And, of course,  
7 throughout this process no one -- SBH-Kingsport has  
8 claimed -- no one has questioned -- that it will taken  
9 involuntary commitments.

10 The final one on Page 5 under Need  
11 is "The proposal's relationship to the policy as  
12 formulated in, in this case, the state plan." And I  
13 would say Mr. Sullivan has set forth our proposal is  
14 consistent with the State Health Plan.

15 The next factor is "The proposal's  
16 relationship to underserved geographic areas and  
17 underserved population groups should be a significant  
18 consideration." Once again, there's no inpatient  
19 providers in Hawkins County. There's only 12 beds  
20 in Sullivan County. There's not any in the three  
21 counties we identified in Virginia. So we are meeting  
22 the needs of an underserved area.

23 And then the issue that's caused some  
24 controversy at the hearing, "The impact of the  
25 proposal on similar services supported by state

1 appropriations should be assessed and considered."  
2 First of all, Mr. Shaheen has made it clear, he's  
3 willing for SBH-Kingsport, LLC, to have its own --  
4 to execute a grant with the Department of Mental  
5 Health and Substance Abuse Services.

6 I don't think he's been -- I don't think  
7 anyone has said that he wouldn't -- that he's not  
8 being truthful in that regard. And so that will not  
9 increase state appropriations. It will cause -- the  
10 state sets the cost, the hospital accepts it, and it  
11 might even cause the state cost to fall if there's  
12 some competition for that service.

13 And the other thing to -- the vital other  
14 fact to remember on this point is that the state grant  
15 contract between -- for mental health and substance  
16 abuse services for these is not with Woodridge, it's  
17 not even with Johnson City Medical Center, it's with  
18 Mountain States Health Alliance.

19 So if the impact of the proposal on  
20 similar services is supported by -- if it's deemed  
21 to be applicable in the state in this case, in this  
22 matter, to state -- to services -- similar services  
23 supported by state appropriations extends beyond the  
24 regional mental health institutes, the nearest one of  
25 which is in Chattanooga, then the impact on Mountain

1 States Health Alliance, not the impact on Woodridge,  
2 should be the one considered.

3 Number 4, "The proposal's relationship  
4 to whether or not the facility takes voluntary or  
5 involuntary admissions that will serve acute or  
6 long-term patients should be assessed." It will take  
7 involuntary admissions.

8 "The degree of projected participation  
9 in Medicare and Medicaid." Clearly, they anticipate  
10 significant Medicare and Medicaid volume.

11 The next one is "Relationship to existing  
12 similar services in the area." Once again, in the  
13 area, we believe, tracks the statutory language of in  
14 the area to be served, which is our service area.  
15 And not only does this one address occupancy and  
16 utilization, but it addresses trends in occupancy and  
17 utilization.

18 Mr. Sullivan has indicated the facility  
19 -- the 12 beds in Bristol, the trend is up in  
20 utilization. The utilization is up. And even if  
21 outside of our service area, you look at Woodridge, of  
22 course, there's no question, both -- the trends are  
23 both -- up for both occupancy and utilization, even  
24 though it's not in our service area, and they're up  
25 radically since the data was set, the data that was

1 available when Mr. Garone filed the CON application.  
2 It's moving close -- as I calculate, it's well over  
3 86 percent and it appears to be moving higher based on  
4 Ms. Bailey's testimony.

5           And the final factor on this -- under  
6 this one is "Accessibility to special needs groups."  
7 Dr. Trivedi said in his report that SBH-Kingsport and  
8 Woodridge, as I recall it, both could serve mild  
9 cognitive impairment, so there are some patients with  
10 mild cognitive impairment. There is some indication  
11 of that as well.

12           And then the final one is "The ability  
13 of the applicant to meet the mental health licensure  
14 requirements should be considered." I think  
15 Mr. Shaheen's testimony establishes that this is a  
16 company that's been successful in a number of other  
17 states in developing and operating psychiatric  
18 hospital facilities.

19           He will improve the supply of  
20 psychiatrists in -- "he" -- the company will, because  
21 its done so in other areas. And there's no reason and  
22 there's been no testimony to indicate that he would  
23 not meet this criterion as well and satisfy the mental  
24 health services requirements.

25           And I apologize for being so long, but

1 it's been a long hearing and I felt like I needed to  
2 cover those factors. Thank you, Your Honor.

3 THE COURT: Thank you.

4 MR. JACKSON: May I proceed, Your Honor?

5 THE COURT: Yes.

6 MR. JACKSON: May it please the Court, on  
7 behalf of Mountain States Health Alliance, and I know  
8 I speak for all the counsel in the case, I want to  
9 thank the Court for its careful attention during this  
10 last, now, five days. We all appreciate the attention  
11 that Your Honor has given to our case, and sometimes  
12 the testimony's kind of dry, so we especially  
13 appreciate it.

14 I did request closing argument today just  
15 so I could summarize for Your Honor why we believe the  
16 Agency was correct when it denied the application for  
17 a CON in this case. And first, with respect to the  
18 criterion of need, which is maybe the most important  
19 or certainly the starting point for any discussion as  
20 to whether a new hospital should be approved, we  
21 submit that the proof has been overwhelming that  
22 the small service area that was proposed in this  
23 application was just not reasonable, as is clearly  
24 required by our rules. This fact was established  
25 by Dr. Collier's testimony, by the admissions on

1 cross-examination by Mr. Sullivan, and by the other  
2 evidence that we've presented.

3           So what do we look at to determine  
4 whether or not this service area was reasonable? I  
5 would submit, first of all, look at the Woodridge  
6 service area. Most of the patients in Sullivan County  
7 today who are getting inpatient psychiatric treatment  
8 are coming to Washington County to Woodridge. And a  
9 substantial number of those, as Mr. Sullivan admitted,  
10 will be redirected to the new facility if it were to  
11 be approved.

12           Overall, admissions from the claimed  
13 SBH service area today account for 36 percent of the  
14 admissions to Woodridge. And that's on Page 5 of  
15 Dr. Collier's report, which is Exhibit 381 to our  
16 proceeding.

17           So it is clear, if we look at the current  
18 state of affairs in this part of Tennessee, that there  
19 is patient flow going from the claimed service area of  
20 this new facility to Woodridge in Washington County.

21           Also, we need to know will patients from  
22 Woodridge's service area in Washington County and  
23 other areas on the south, will they be utilizing this  
24 new facility if it is constructed? That's another  
25 important issue. Because a service area just means

1 where are the patients going to be coming from?

2 And for that question we look to the Indian Path  
3 Psychiatric Pavilion.

4 When psychiatric services last existed  
5 in Kingsport just a few years ago, the flow went the  
6 other way as well, meaning people from Washington  
7 County, residents of Washington County, were going up  
8 to Kingsport to get treatment at that facility owned  
9 first by HCA and then ultimately by Mountain States,  
10 before it was closed.

11 Residents of Washington County accounted  
12 for 12 percent, approximately, of the admissions at  
13 Indian Path Psychiatric Pavilion. And that's on Map 3  
14 of Dr. Collier's report that we've made Exhibit 381.  
15 That's the second highest total of any county.  
16 Sullivan County was Number 1, obviously. Washington  
17 County was right behind it as Number 2. And that  
18 makes sense because of the population.

19 And, Your Honor, the exclusion of  
20 Washington County doesn't make any sense in terms of  
21 either where the population is today or where it's  
22 growing in the future. As Dr. Collier pointed out,  
23 the south -- to the south from Sullivan County is  
24 where a very substantial number of people live. There  
25 are almost, I believe, 150,000 people in Washington

1 County. It's a very highly populated county. And  
2 Mr. Sullivan acknowledged that the population growth  
3 in the claimed service area of SBH is basically flat,  
4 but there is population growth to the south in  
5 Washington County.

6 And, in fact, in child and adolescent,  
7 which are a critical part of this application, the  
8 population is actually declining in the claimed  
9 service area and growing in Washington County. And  
10 that's especially important because even the applicant  
11 admits, as Mr. West just did a minute or two ago, that  
12 it is adding more child and adolescent beds than the  
13 state formulas would allow, even if you accept their  
14 small and, we would submit, unreasonable service area.

15 So to fill those 28 child and adolescent  
16 beds is going to require them to draw patients from  
17 a broader geographic area than they are claiming in  
18 their application. It is simply indisputable that  
19 these children and adolescents, to fill those, what  
20 they even admit are excess beds, are going to have  
21 to come from Washington County and the other -- the  
22 southern counties, I'll call them, that they've  
23 omitted from their service area, so -- because there's  
24 just not enough to support a 28-bed unit in their  
25 claimed service area.

1 Excluding Washington County also doesn't  
2 make any sense in terms of population density, which  
3 is something the applicant didn't even discuss and  
4 Mr. Sullivan didn't even discuss. They've proposed a  
5 service area to the north, when, as I've already  
6 mentioned, the major population center is to the  
7 south. And if you look at the road access and the  
8 flow of people, it's clear that you've got, to the  
9 south, Washington County with a dense population,  
10 and you'll recall we submitted maps from Dr. Collier  
11 showing these clusters of population on the northern  
12 end of Washington County -- and there's an interstate  
13 highway connecting the two cities. I mean, it is  
14 the Tri-Cities. It's not the duo-cities or the  
15 one-and-a-half cities; it's the Tri-Cities. Bristol,  
16 Kingsport, and Johnson City have been recognized for  
17 many years as a unified socioeconomic region or part  
18 of our state and it's, of course, a combined  
19 statistical area.

20 But you've got this population to the  
21 south with roads to the south and then you've got  
22 mountains to the north and much less accessible and a  
23 much smaller population, including even -- you've got  
24 Lee County which has about 25,000 people in it, which  
25 is one of the counties claimed, while they're ignoring

1 Washington County with some 150,000.

2           The small service area also doesn't  
3 make any sense, Your Honor, in light of the fact  
4 that inpatient psychiatric services are far more  
5 regionalized or centralized than are other health  
6 care services. That was admitted by -- well, it  
7 was testified to, really, by everybody who addressed  
8 it in this case, including Mr. Sullivan even this  
9 morning, in my examination of him this morning.

10           Psychiatric services are regional in  
11 nature, meaning you don't expect to have inpatient  
12 psychiatric wards -- that's what we're talking about  
13 here, not mental health services but inpatient  
14 psychiatric wards -- you don't expect to have those  
15 scattered about in every small community in the  
16 region. That's not how it works.

17           It's neatly illustrated, I think, this  
18 issue of disbursal of resources and centralization of  
19 resources by an exhibit that Mr. West offered through  
20 Dr. Jessee, which is Exhibit 248, and that's the  
21 Frontier map showing where Frontier has all of its  
22 places.

23           And remember that Frontier is a  
24 community-based provider. It's not an inpatient  
25 provider. It provides outpatient services, all the

1 many important things that Dr. Jessee described  
2 for us. And they're doing that, as they should,  
3 throughout the area. They're sending out their  
4 mobile teams throughout the area. That's  
5 decentralized services, and that's good. That's a  
6 healthy thing for the health care system in Upper East  
7 Tennessee.

8 Inpatient psychiatric wards, which are  
9 the thing that we are -- all these people are trying  
10 to avoid having to put patients in are, by definition,  
11 more centralized. They are in the bigger cities.  
12 They are not scattered out in the smaller communities.

13 And that makes sense, if you think about  
14 it, because Frontier, as Dr. Jessee testified, is  
15 touching far many more lives than is any inpatient  
16 facility anywhere. I mean, Frontier has seen 40,000  
17 patients a year. Thank goodness there aren't 40,000  
18 people a year being locked up in a psychiatric ward.  
19 That's not -- there's no comparison there. It's a  
20 much broader service helping people to get well before  
21 they have to be committed to a psychiatric ward.

22 And on this issue of whether there's  
23 a small or large service area that's appropriate,  
24 remember that the service area of Lakeshore which was  
25 coterminous with the Department of Mental Health's

1 Region 1 planning system was 24 counties. So, again,  
2 showing that -- these kind of psychiatric services,  
3 for planning purposes, are looked at on a broader  
4 region than the small service area that's proposed.

5 Your Honor, the senselessness, really,  
6 of excluding Washington County, I think, is best  
7 evidenced by the fact that as we learned in our case,  
8 SBH itself was planning on actually putting this  
9 facility in Washington County in Johnson City, and  
10 they moved it, not because they did some analysis and  
11 determined the need was in Kingsport but because they  
12 didn't want to get in a CON dispute, and that's, of  
13 course, Exhibit 325, which is Mr. Garone's email where  
14 he divulged to someone else the reasons why the  
15 project had been moved from Johnson City to Kingsport.

16 But all of the internal analyses, such as  
17 it was, that was done by SBH in this case included  
18 Washington County. Remember the intern's project,  
19 that looked at all those factors in the Tri-Cities as  
20 a whole, not in this claimed service area. Remember  
21 the catchment area in the Dobbs presentation. That  
22 was Exhibit 10 to Mr. Shaheen's testimony. That's  
23 what they looked at for internal purposes. Remember,  
24 they drew two circles and they were looking at that to  
25 see, as he acknowledged, where the patients would be

1 coming from; in other words, what would the service  
2 area be.

3 And we would submit that these internal  
4 documents are where we should look if we're evaluating  
5 the reasonableness of their public claims that, oh,  
6 we're just really going to be marketing to these three  
7 counties in Virginia and two counties in the northern  
8 edge of Tennessee.

9 From all of this it's clear, Your Honor,  
10 that the service area of this project, the area that  
11 will be served by the project must be and is bigger  
12 than that claimed in the application. So it's further  
13 undisputed that if you do apply a larger reasonable  
14 service area, then no need has been established for a  
15 new 72-bed hospital. The numbers just don't work out.

16 But, Your Honor, formulas aren't  
17 everything and the guidelines aren't everything, so  
18 I think it's appropriate that we look -- sometimes,  
19 as Your Honor knows, you may have to look beyond the  
20 guidelines and find need if the evidence supports it.  
21 And so we've heard some testimony about things in this  
22 case, which I want to address, to show that there's no  
23 need either through the guidelines or through any  
24 other metric that we might look at.

25 If we look at out-migration -- this is an

1 important analysis, because out-migration means that  
2 patients are having to leave the area to go get help  
3 somewhere else if they need inpatient services. In  
4 this case, they're having to go somewhere else.

5 Well, Page 12 of Exhibit 9, which is the  
6 CON application, contains a chart of out-migrating  
7 patients, which I discussed with Mr. Sullivan, and  
8 what it showed was basically there's no out-migration  
9 to Nashville of any consequence -- I think there were  
10 four or five patients -- none to Memphis. There was  
11 a very small number going down to the state facility  
12 in Chattanooga, Moccasin Bend, and then there were  
13 about 200 patients going to Peninsula in Knoxville,  
14 which is, first of all, not that far away, but second  
15 of all, it's a very small number of patients,  
16 200-and-some-odd patients.

17 That's not a significant out-migration  
18 issue, and it's also not enough to fill 2,000 cases  
19 which are projected in Year 2 even at low occupancy  
20 of this new hospital. So if you look at the  
21 out-migration, that doesn't provide us with any  
22 indication that this is an area in need of psychiatric  
23 inpatient services.

24 You can look at drive times. Everyone  
25 agrees that's another way to evaluate whether adequate

1 access to a facility. And we all agree -- I think all  
2 the experts agree that one hour is a reasonable drive  
3 time. The TennCare standard, you'll recall, which  
4 we've entered into evidence, is 90 minutes, so even a  
5 little longer than an hour.

6 Everyone, though, in this broader area  
7 lives within reasonable drive time of inpatient  
8 psychiatric services. There's been no evidence that  
9 anyone -- and, in fact, in Dr. Collier's report, she  
10 has a map where she demonstrates this, that there's no  
11 one able -- there's no one who's out of whack in that  
12 they're too far away from an inpatient resource should  
13 that become necessary for them.

14 We also can look at use rates to see if  
15 the use rates require -- or suggest that there's some  
16 unmet need in the community. In Dr. Collier's report,  
17 in her report at -- Exhibit 16 to her report, which  
18 was Exhibit 381, she shows that the use rate in this  
19 area is at or near the -- excuse me -- above or near  
20 the Tennessee average; that she's testified there was  
21 no use rate of any of these counties that was more  
22 than a couple -- one or two standard deviations from  
23 the mean, which she said didn't bother her at all --  
24 or indicate to her at all that there was a problem  
25 with use rates.

1           She also testified that as far as the  
2 state use rate goes, we're right in the middle of the  
3 United States. We're not too low -- we're not low in  
4 comparison to the other states, and that testimony was  
5 uncontradicted by Mr. Sullivan. So there's no basis  
6 to conclude -- in fact, the information came from  
7 appendices to his own report, I would add. So there's  
8 no basis to conclude from the use rates in this case  
9 that's there any impairment to access to inpatient  
10 psychiatric services.

11           Then we can look next -- another factor,  
12 and the guidelines require it, look at utilization of  
13 existing facilities. And I want to say first that all  
14 we've heard about in this case from the applicant is  
15 Woodridge, Woodridge, Woodridge, Woodridge. And that  
16 makes sense because Woodridge is the leading provider  
17 of psychiatric services, but it's not the only  
18 provider of psychiatric services in this area. And if  
19 you look around at them, as Dr. Collier did, they're  
20 just not that busy.

21           Exhibit 15 to her report, which is  
22 Exhibit 381, shows that there's a 63 overall occupancy  
23 rate in all of the facilities in her service area over  
24 a three-year period, the most recent three-year period  
25 for which she had data at the time. That reflects

1 there's capacity in the system, and, again, not  
2 supportive of a case for need.

3 Now, the applicant has spent a great  
4 deal of time talking about the volumes at Woodridge.  
5 There's no question that Woodridge is a busy hospital,  
6 and it's gotten busier over the last couple of years.  
7 And that's a good thing in that that means existing  
8 resources are being utilized. The investments that  
9 have been made already in the system are paying off  
10 and patients are getting care.

11 The proof is undisputed that the  
12 occupancy at Woodridge is the same as the occupancy at  
13 basically every operational SBH facility and even at  
14 Vanderbilt, as we heard from Dr. Trivedi. So there's  
15 not -- there's no proof to support the conclusion that  
16 having an 80 or 85 percent occupancy rate is the sign  
17 of distress or lack of adequate capacity in the  
18 system. That's just not a fact that's been  
19 established in our case.

20 You've been directed to these flow  
21 sheets. We had a lot of testimony about the flow  
22 sheets, but those are misleading snapshots in time,  
23 as I think the testimony of Ms. Bailey established.  
24 These are internal flow sheets that are kept at a  
25 particular point in day to track who's coming in and

1 who's going out and where are beds going to become  
2 available.

3           Beds open up -- most of those people,  
4 she testified, on that waiting list -- first of all,  
5 they're all getting some kind of care when they're on  
6 the waiting list. They're not left out in a hallway  
7 by themselves. They're getting care. They're getting  
8 treatment. And many of them are going to be in beds  
9 within a few hours of that flow sheet's completion.

10           There has not been one case identified in  
11 our proceeding of any person living in any of these  
12 counties who has ever been denied access to needed  
13 inpatient care as a result of bed availability. We  
14 have not had any evidence to support that.

15           The flow sheets have been introduced  
16 and deferral patterns, but the testimony's undisputed  
17 the deferral numbers don't mean someone is sent away  
18 without care. They may be sent just down the road  
19 to one of these other facilities which has ample  
20 capacity. They may be sent elsewhere. But there's  
21 not been any evidence offered in this case to support  
22 the conclusion that any person, one person, has been  
23 denied care because of the lack of a bed, much less  
24 that there's a systemic issue that necessitates the  
25 construction of a costly new hospital in Kingsport.

1           Now, the applicant, through Mr. Sullivan,  
2 has made a lot of sweeping assertions about the loss  
3 of public beds, but I think that both Dr. Trivedi and  
4 Dr. Collier made it clear that the public and private  
5 patient mix are very different, that, in fact, any  
6 problems that may be arising from a lack of public bed  
7 capacity can't be translated to mean that we need more  
8 private beds.

9           Tennessee actually has more private beds  
10 than the US average and it has more than State Health  
11 Plan suggests is ideal, which is 30 per 100,000. And,  
12 of course, if you take isolated counties or silly  
13 service areas, you can say that this particular area  
14 doesn't have enough beds. That's why a service area  
15 is so critical, because you must choose a reasonable  
16 service area in order to come up with a meaningful  
17 analysis under the beds-per-100,000 rule.

18           We've also heard about the Affordable  
19 Care Act and the suggestion has been made that this is  
20 going to lead to all these patients coming into the  
21 system, which is inherently speculative and, I would  
22 submit, a little illogical given that the premise is  
23 that suddenly under the Affordable Care Act, people  
24 are going to have insurance and they're going to be  
25 able to get inpatient psychiatric care.

1 Well, if you live in this area now  
2 and you don't have insurance, you can get inpatient  
3 psychiatric care. It's from a place called Woodridge.  
4 That's the whole point of the state grant, is that  
5 patients who are uninsured or whose insurance doesn't  
6 cover psychiatric treatments can come to Woodridge and  
7 they still get admitted and treated as patients and  
8 thousands of them have done so in the recent years.

9 So the idea that the Affordable Care  
10 Act is suddenly going to open up a floodgate of new  
11 patients is simply not supported by the evidence.  
12 These patients already have access to care through the  
13 state grant program. It's just now, though, become  
14 insured patients, but there's absolutely no basis to  
15 conclude there will be more of them.

16 Finally, on the issue of need, if there  
17 was an actual, real, pressing community need in  
18 Kingsport, Tennessee, don't you think that this  
19 applicant, with all of its resources and its able  
20 counsel, would have brought us just one witness  
21 from the community that we're talking about who lives  
22 there and will be living there in the coming months  
23 and years, whether it was a doctor, a patient, a  
24 volunteer, a community worker, a nurse, a therapist,  
25 anybody from Kingsport, supposedly this place that is

1 clamoring for more inpatient psychiatric beds?

2           Instead, Your Honor, what they brought  
3 us was Dr. Elliott. First he told us that he lives  
4 in Gray, Tennessee, but we learned shortly thereafter  
5 that he's actually moving. He's literally -- I mean,  
6 I think he left -- he may have -- he literally was on  
7 his way to Michigan, as he testified. He may have  
8 left his U-haul or his Winnebago with the engine  
9 running downstairs when he came up here to testify  
10 in this case.

11           And what he told us when he got  
12 here -- he clearly had some ax to grind with ETSU,  
13 which I didn't really understand completely, but  
14 apparently they're on probation and he turned them  
15 in as he left. I didn't really know what that had  
16 to do with this project, but what he told us is stuff  
17 about that and -- but they had found us no -- then he  
18 literally left the courtroom and presumably drove up  
19 the interstate to Louisville or wherever and on his  
20 way to Michigan where he will be practicing in the  
21 future.

22           No doctor who's actually practicing in  
23 this community or who's committed to the future of  
24 this community has come in here to tell Your Honor  
25 that there's a need for this project, not a single

1 witness, despite all the resources on the other sides.

2 We brought you, by contrast, Dr. Jessee,  
3 who, as I have mentioned, is already treating 40,000  
4 people -- his organization, Frontier, is treating  
5 40,000 people in the area. And among other things, he  
6 told Your Honor about the crisis stabilization unit.

7 And what this shows, among other things,  
8 in addition to showing that it will have a positive  
9 impact on future demand for child and adolescent beds  
10 -- or adolescent beds -- excuse me -- in addition to  
11 showing that, it shows that Mountain States is meeting  
12 the needs of the community, trying to improve access  
13 to mental health services generally and not by just  
14 building more inpatient beds.

15 And now I've heard several responses  
16 to the CSU from the other side. First I heard the  
17 implication it really wasn't going to happen; it was  
18 just made up somehow. And then I guess that didn't  
19 sound too believable after three or four people came  
20 in and said they'd been to numerous meetings about it,  
21 you know, they were working on protocols, they were  
22 putting everything together, so then it became, well,  
23 you can't get it licensed, but then we brought the  
24 chairman of the licensing board himself, Dr. Jessee,  
25 who said -- I presume he's smart enough to know that

1 the project he's working on is probably going to get  
2 approved by the board that he's chairman of.

3 Then we've heard, well, you know, this  
4 all just reactive to this problem. Well, however it  
5 came up, what it shows is Mountain States, working  
6 with partners in the community, is collaborating and  
7 doing its best to help meet the needs for mental  
8 health treatment in this area, and that's not just  
9 through the admission -- or building and creation of  
10 more inpatient beds to drive in patient volumes.

11 And it is clear that the outpatient  
12 component of the applicant's project is an  
13 afterthought. There's not much detail about it in the  
14 application. It accounts for a very small percentage  
15 of the revenues of this project, if you look at the  
16 application. So their application is about inpatient  
17 volumes. That's how this company makes money.  
18 Nothing wrong with that, but that is not what is  
19 needed in this community.

20 Your Honor, with respect to the other  
21 factors, economic feasibility, I would simply point  
22 Your Honor to the testimony of Dr. Collier, and I  
23 think she made a very good point. How can you really  
24 assess the financial viability when you don't have  
25 reliable admissions projections and you don't really

1 know where these admissions projections are coming  
2 from? They're just asserted that this is from our  
3 experience, so here they are. How can you really  
4 judge that? So remembering that it is their burden  
5 to prove this, I don't think they've satisfied that  
6 burden.

7           And another important component of  
8 economic feasibility is alternatives. And there has  
9 been -- it is abundantly clear there's been no serious  
10 consideration of any alternative to building a 72-bed  
11 project. In fact, the 72-bed project itself is an  
12 off-the-shelf design that SBH has in its offices in  
13 Memphis that they can put anywhere, whether it's Green  
14 Bay or Miami or wherever; they just drop this 72-bed  
15 model down. And that's the antithesis of orderly  
16 planning.

17           It's a topdown approach that says one  
18 size fits all. And this project, as Mr. Sullivan  
19 admitted, when you do a thoughtful planning analysis,  
20 you figure out organically how much does this  
21 community really need in bed terms. You don't just  
22 look on the shelf and say, I have a 72 -- I don't have  
23 to pay another architect to draw up a different size  
24 facility because I've already got my 72-bed facility  
25 here; let's put that one in Kingsport. You actually

1 consider alternatives. That was never done in this  
2 case.

3 Now, in the orderly development prong,  
4 finally, Your Honor, you know, we've had a lot of  
5 quibbling in the case about is the medical center  
6 and is the -- Woodridge a satellite of the medical  
7 center, and are these charity numbers real charity or  
8 not-so-real charity or whatever. I think we heard  
9 from Mr. Levine today, and I think it's pretty much  
10 undisputed, that the folks at Mountain States Health  
11 Alliance are providing many tens of millions of  
12 dollars in undercompensated or uncompensated care to  
13 the folks living in Upper East Tennessee and Southwest  
14 Virginia. It is the major health care provider for  
15 hundreds of thousands of people who live in that part  
16 of our state and the Commonwealth of Virginia. It is  
17 undisputed that they are a pillar of the TennCare  
18 system in the state and have been since its inception.

19 And while I agree that a for-profit and  
20 not-for-profit entities have to be treated equally in  
21 the CON process -- that is absolutely the case, but  
22 you also do have to take into account the impact on  
23 existing providers. And in this case it so happens  
24 that the existing provider is a very important  
25 nonprofit system that is contributing, over the course

1 of just a few years, hundreds of millions of dollars  
2 of community benefit to the folks who live in Upper  
3 East Tennessee and Southwest Virginia, which is, as  
4 Your Honor knows, an underserved area. It's not an  
5 area that is full of rich, well-insured people, in  
6 many instances, and it is a place that needs the help  
7 that Mountain States is giving it.

8           And just because the medical center,  
9 which is a major tertiary care hospital -- just  
10 because the medical center is, fortunately, performing  
11 in a good way right now, generating good income,  
12 does not mean you just disregard the fact that this  
13 duplicative service would be stripping away up  
14 to \$2 million or more from the bottom line of that  
15 operation, and that's particularly true given what  
16 Mr. Levine told us about the bond rating of the  
17 organization as a whole, the challenges that he faces  
18 in managing this extremely complex system that is up  
19 there that is so critical for contributing to the  
20 health care of Tennessee.

21           And remember what Dr. Trivedi told us?  
22 He came to Vanderbilt, Vanderbilt University, right  
23 down the street, with I don't know how many billions  
24 of dollars in endowment that Vanderbilt has and all of  
25 its massive resources, and when he was hired and

1 brought in to run the psychiatric hospital there, they  
2 were about to sell it off to a for-profit provider  
3 because it was losing a few million dollars a year.

4           So that testimony alone tells us, you  
5 know, losing a few million dollars a year may seem  
6 like, you know, nothing if you look at the vast  
7 resources of Vanderbilt University, but it obviously  
8 was significant enough to them to actually put them  
9 on the road of divesting themselves of their entire  
10 psychiatric hospital. So I think that is another bit  
11 of evidence that shows us what the significance of  
12 this impact will be.

13           And, Your Honor, in these cases I think  
14 of the impact analysis. You know, every project has  
15 a negative impact on the existing providers, so you  
16 could just throw up your hands and say, well, it's  
17 always a negative impact. How am I ever going to find  
18 that it's too much or too little? Just forget about  
19 that factor.

20           Well, I think it's more appropriate to  
21 think of it as a sliding scale. The more need you  
22 have, then the more impact the system may allow. In  
23 other words, if you have an area that is lacking in a  
24 particular service and there's a demonstrated strong  
25 need for the service, then you may say, okay, we're

1 going to allow more impact. If you have -- in a case  
2 like this, where you have existing resources already  
3 in the region which are not fully utilized, then the  
4 need is very, very low, and the tolerance that we  
5 would have for impact should be very low as well.

6 So, in conclusion, Your Honor, I think,  
7 based on all this evidence that you've heard and the  
8 testimony that's been presented in this case, we would  
9 urge you to find, as the Agency did, that this case  
10 has not been -- the burden of proof has not been  
11 met in this case and that the Certificate of Need in  
12 question for a new hospital should be and was properly  
13 denied.

14 Thank you, Your Honor.

15 THE COURT: Thank you. Mr. West,  
16 rebuttal?

17 MR. WEST: Your Honor, my only rebuttal  
18 is that I disagree with Mr. Jackson's conclusions, but  
19 in the interest of not extending this any further, in  
20 terms of taking up the Court's time, I don't have a  
21 long and formal statement to that.

22 THE COURT: I will take the matter  
23 under advisement. And, to that end, let's talk about  
24 proposed findings of facts and conclusions of law.

25 Have you-all discussed this on your own?

1 MR. JACKSON: We haven't, Your Honor. I  
2 have a proposal I can share with them.

3 MR. WEST: Go ahead. You have the floor.

4 MR. JACKSON: The way we've done it --  
5 this is just the way I did it in the last one of  
6 these, I think, is we would like the transcript, I  
7 think, both sides. So what I would suggest is 60 days  
8 from the receipt of the transcript that we would  
9 submit them. Does that sound reasonable?

10 MR. WEST: Your Honor, given the length  
11 of the exhibits and everything, I think that's  
12 reasonable, if that meets with Your Honor's --

13 THE COURT: I think that's acceptable.  
14 And sometimes something that plays into your decision  
15 is your schedule with other matters and the day the  
16 transcript arrives and then the clock's ticking and  
17 what you have in the future weeks, and so that's why I  
18 was giving you-all some leeway with that.

19 MR. JACKSON: Thank you, Your Honor.

20 (Discussion off the record.)

21 MR. JACKSON: Thank you very much, Your  
22 Honor.

23 THE COURT: Is there anything else we  
24 need to take up, counsel?

25 MR. CHRISTOFFERSEN: Actually, Your

1 Honor, I do have a question.

2 THE COURT: Okay.

3 MR. CHRISTOFFERSEN: And I'm just  
4 anticipating. This may be much ado about nothing,  
5 but are you considering the possibility anybody might  
6 want to file a rebuttal of the other side's proposed  
7 findings, or is that just something you'd just rather  
8 not see?

9 THE COURT: Well, that's up to you-all.  
10 It hasn't been mentioned.

11 MR. JACKSON: I've never done that, Your  
12 Honor. I'm happy just each side submitting their  
13 proposed findings.

14 MR. WEST: Your Honor, like Mr. Jackson,  
15 I've been doing this a long time. I don't want to say  
16 I've never done it. It's been pretty rare. But I  
17 think I may have done it in the past. I'd like to  
18 reserve the right, if possible, to do that, but given  
19 the press of our other cases and everything, I find it  
20 fairly unlikely.

21 THE COURT: Well, if we're going to do  
22 it, I'd rather make a determination now and then set a  
23 deadline. So if it's something you're interested in  
24 doing, we need to go ahead and address it at this  
25 moment so we could put a time frame on it.

1 MR. WEST: I would say two weeks at most.

2 MR. JACKSON: That's fine with us, Your  
3 Honor.

4 THE COURT: So we'll say each side has  
5 two weeks after the filing of proposed findings to  
6 file any rebuttal.

7 MR. SWEARINGEN: Typically, Your Honor,  
8 we submit that to you as a Word copy?

9 THE COURT: Yes. If you need to, file a  
10 hard copy with APD and then email me a Word copy. I  
11 would appreciate that.

12 Anything else?

13 MR. JACKSON: Nothing further, Your  
14 Honor.

15 THE COURT: Thank you-all for your time.  
16 I appreciate counsel's professionalism. You've both  
17 done an excellent job representing your clients.

18 MR. WEST: Thank you.

19 MR. JACKSON: Thank you, Your Honor.

20 THE COURT: That concludes our hearing.

21 (Proceedings concluded at 12:28 p.m.)  
22  
23  
24  
25

REPORTER'S CERTIFICATE

1  
2  
3 We, Sabrina L. Schneider and Emily L.  
4 Sipe, Notaries Public and Licensed Court Reporters, do  
5 hereby certify that we recorded to the best of our  
6 skill and ability by machine shorthand all the  
7 proceedings in the foregoing transcript, and that  
8 said transcript is a true, accurate, and complete  
9 transcript to the best of our ability.

10 We further certify that we are not  
11 attorneys or counsel of any of the parties, nor a  
12 relative or employee of any attorney or counsel  
13 connected with the action, nor financially interested  
14 in the action.

SIGNED this 17th day of August 2018



15  
16  
17 *Sabrina L. Schneider* -----

18 Sabrina L. Schneider, LCR  
19 Notary Public, State of Tennessee  
20 My Commission Expires: 5/5/2018

21 Tennessee LCR No. 465  
22 Expires: 6/30/2016



23 *Emily L. Sipe* -----

24 Emily L. Sipe, RPR, LCR  
25 Notary Public, State of Tennessee  
My Commission Expires: 4/28/2019

Tennessee LCR No. 608  
Expires: 6/30/2016